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Report and annexes contain details on the establishment of the Civil-Military Alliance to Combat HIV and AIDS. This organization subsequently (1995) received USAID funding and further support and sponsorship from U.N. agencies and in-kind support from several European medical military commands.

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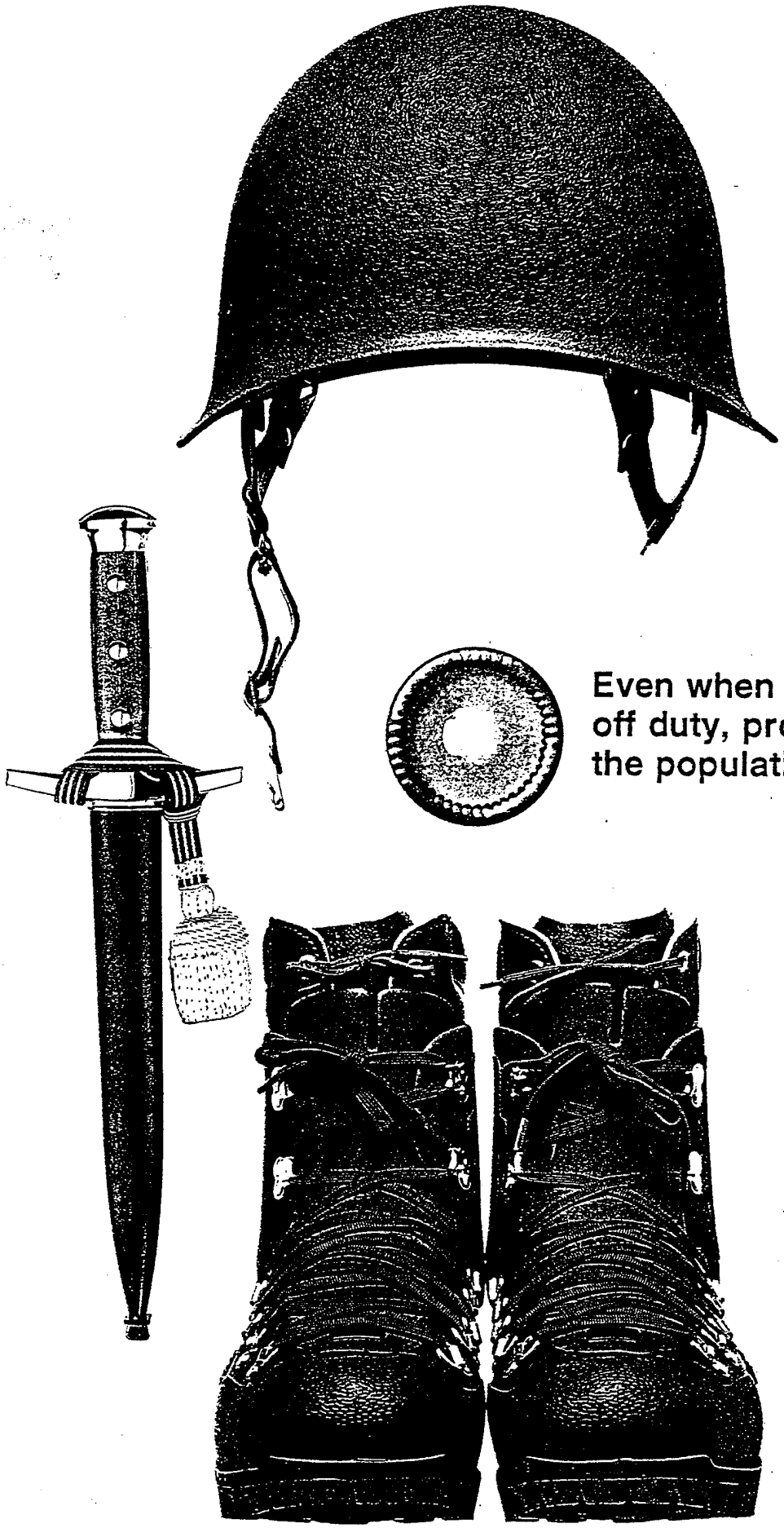

Even when you are off duty, protect the population.

STOP AIDS / STOP SIDA

Campagne de prévention de l'Aide Suisse contre le Sida, en collaboration avec l'Office fédéral de la santé publique.

Civil-Military Alliance to Combat HIV and AIDS

Alliance NEWSLETTER

Volume 1, Number 1 January 1995

Letter of Welcome

We are pleased to invite your participation in the Civil-Military Alliance and to welcome you as a member. The Alliance presently has members from 42 nations. It has been formed as an interest group that brings together individuals in both civilian and military professions concerned with HIV and AIDS.

We hope you will communicate with us about your work and your professional concerns and we hope to be able to provide you with ideas and information that are of benefit.

With best wishes,

Mark De Coninck, Major General (Belgium) Alliance Co-Chair

Ben Mbonye, Secretary to Defense (Uganda) Alliance Co-Chair

Inside:

New International Organization Responds to HIV/AIDS Challenge

R. Neal Boswell and Norman Miller

Responding to the challenge that HIV and AIDS is presenting to military leaders and to the civilian communities near military facilities around the world, a new Civil-Military Alliance to Combat HIV and AIDS has been formed. The Alliance will establish a resource center, carry out training seminars, publish a newsletter, and initiate research useful to its members. Initial funds have been provided by the U.S. Agency for International Development.

The Civil-Military Alliance is designed as an international interest group. It was originally discussed in a conference on Military HIV and AIDS in Berlin in 1993, a meeting attended by representatives of 28 nations. The overall mission of the organization is to focus on issues of prevention, education, policy, and care in civil-military settings.

Another part of the mission is to promote global civil-military cooperation, to encourage policies and strategies useful in fighting AIDS and to facilitate both military to military and civil -military cooperation. A special concern of the Alliance surrounds issues of peacekeeping, including low-intensity conflicts and how HIV transmission can be reduced in such areas of turmoil.

The topical focus of the Alliance includes questions of high risk behavior, prostitution, government policy, AIDS awareness, and the role of non-governmental and community based organizations working near military facilities.

Organizationally, the Alliance will be headquartered for 1995-1996 in Washington D.C. It is planned that the headquarters be moved in 1997 to another international site. Four regional secretariates are envisioned, one each for Africa, Asia, the Americas and Europe. In each will be a modest resource center and communication facility to enhance HIV prevention and training activities in that region. Within each country of the four regions, it is planned that one individual in either a military or civilian office be designated the Alliance "point of contact", this person in effect serving as the Alliance representative in that nation.

Leadership of the new organization is drawn from several nations. Two international chairpersons are designated for 1995-96 and each of the four regions have designated chairs; an international advisory board is being established. Professor Norman Miller, PhD, and Colonel Neal Boswell, MD, have been proposed as co-directors of the Alliance during its first two years.(See organizational chart, page 2).

Alliance: The Issues at Stake

Norman Miller

The Alliance is concerned with control and prevention of HIV and AIDS and military personnel, their families and their communities. (See Figure l, page 3)

Issues of special concern also fall into three broad sectors: those concerning military to military relations, those concerning civil-military relations, and those concerning peacekeeping issues. (Figure 2).

I. Military to Military. The Alliance hopes to foster exchanges between militaries on the issues of prevention and control of AIDS. These include joint training exercises, seminars in clinical treatment, ways to encourage behavioral change in specific national settings that are sensitive to the local culture, and issues of the care and support of soldiers with HIV or AIDS.

II. Civil-Military. Relations between civilian and military organizations are often fraught with misunderstanding particularly in nations where militaries are changing rapidly. An example of this lies in situations of rapid demobilization—found currently in Africa — where soldiers are being returned to civilian status. Demobilization can mean economic hardship, family hardship and in a broader context political instability. Unemployed men who have military training and access to weapons can pose serious threats to civilian authorities, particularly if HIV/AIDS is a personal factor among demobilized troops. One way of defusing demobilization problems is to provide job training and alternative income. Such training for example might be aimed at equipping former soldiers with the skills of peer educators to be used in AIDS prevention work.

The Alliance also hopes to draw attention to the circumstances of military wives and families, to issues that include education for wives, access to information, access to condoms and issues of empowerment for women in high risk situations. Prostitution around military basis is an age-old problem that has traditionally focused upon sexually transmitted disease, and more recently HIV and AIDS. Gender issues are important, as well as the use of drugs and alcohol in military populations particularly in there links with HIV infection.

III. Peacekeeping. Some 73,000 blue-helmet peacekeepers are currently deployed on 17 UN missions.During the last 15 years over 600,000 peacekeepers have been engaged. It is likely that more peacekeepers have died of AIDS, or will die because they are HIV infected—-than have lost their lives in the line of duty.

Special issues of concern to the Alliance are to provide or help facilitate predeployment briefings for UN soldiers coming from the many contributing nations. Parallel concerns surround issues of testing troops before they are deployed, of ways to reduce risk of AIDS once troops are deployed, and of reducing risk of infection in a soldiers' home country once they have returned. Obviously a number of difficult diplomatic issues surround these concerns.

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News and Notes should be sent to:
Civil-Military Alliance Newsletter
4 West Wheelock Street
Hanover, NH 03755 U.S.A.
Tel: (802) 649-5296
Fax: (802) 649-2331
Telex: 4930372 RPC UI

Civil-Military Alliance: Defining the Territory

Who are the individuals and the organizations of special concern to the Alliance? In Figure 1, at right, these are seen at three levels.

I. The central focus is military, paramilitary and child soldiers. The central concern is changing their behaviors in terms of risk of HIV and AIDS. Women in militaries around the world are a special concern.

II. Military spouses, children and extended families who often live with or near a member of the military, are an important concern as are other sex partners and commercial sex workers.

III. Surrounding military personnel and their families is a broader sector that includes individuals such as military orphans and child merchants and traders, as well as the communities near military facilities, local and national government offices, and civilian organizations such as churches and other non-governmental organizations.

Figure 1

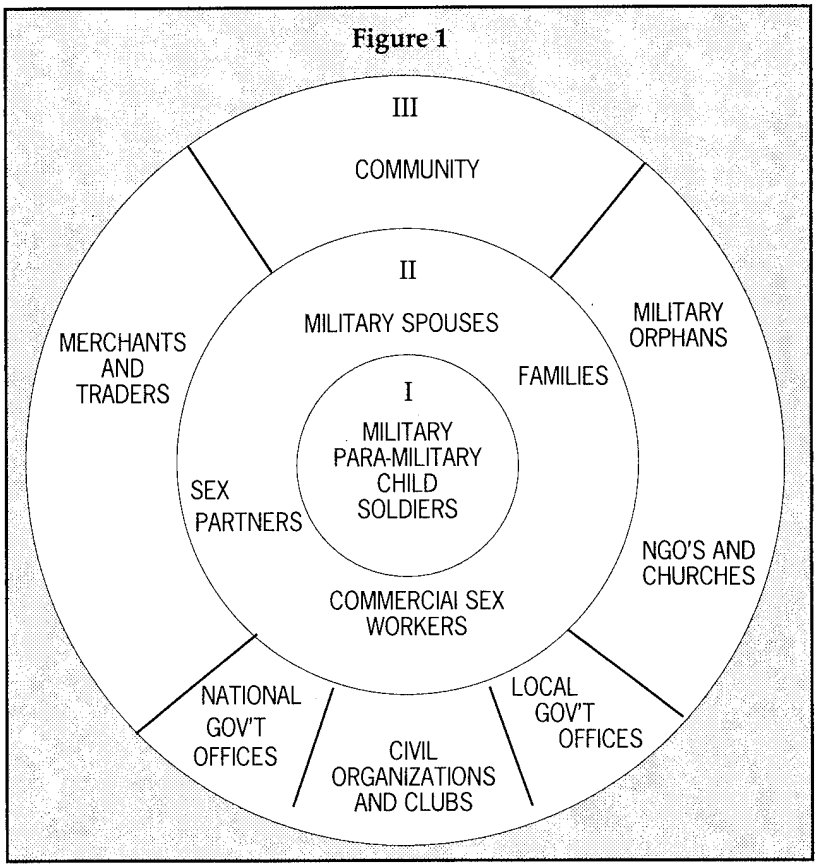
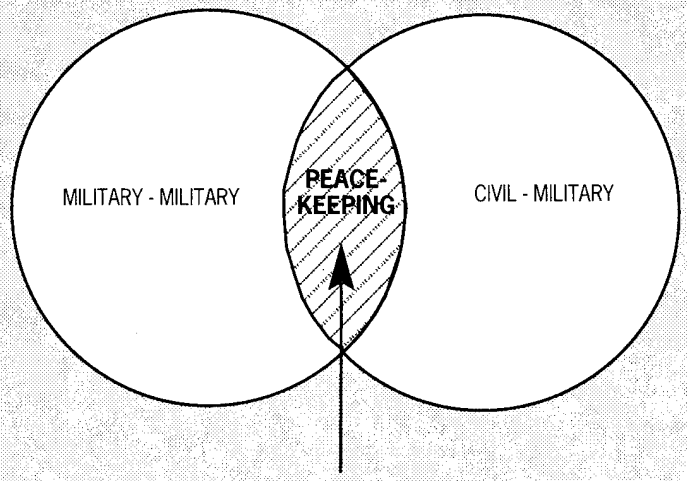


Figure 2

INSTITUTIONAL RELATIONSHIPS

MILITARY - MILITARY

ISSUES
Prevention and Care
Clinical Treatment
Joint Training
Behavioral Change
Policy Issues Concerning
Soldiers With HIV/AIDS



CIVIL - MILITARY

ISSUES
Demobilization
Soldiers as Educators
Military Wives and
Families
Civil-Military Communities
Prostitution
Development

PEACE-KEEPING

ISSUES
Testing, Troop Briefings and Education, HIV Transmission in Blue Helmet Missions,
HIV Transmissions Following Blue Helmet Missions, Diplomatic Issues

CONSENSUS STATEMENT

MILITARY AND CIVILIAN COOPERATION IN RESPONSE TO THE HIV AND AIDS EPIDEMIC

WHEREAS the world now faces a disastrous global epidemic of HIV and AIDS;

Whereas HIV recognizes no boundaries and knows no sovereignty;

Whereas military communities are at risk of HIV and AIDS;

Whereas the HIV and AIDS epidemic is both a serious public health problem and a threat to social and economic development;

Whereas the HIV and AIDS epidemic in many parts of the world poses a potential threat to political stability and national security, and is a potential hindrance to peace;

RECOGNIZING the critical role of a unified, effective, and sustainable national response to the epidemic;

Recognizing further that effective and sustainable HIV and AIDS prevention and care policies and programs demand close cooperation between military organizations and local, national, and international civilian organizations;

WE HEREBY URGE that military organizations around the world:

Immediately cooperate to combat HIV and AIDS as a common threat;

Share lessons learned in the effort to develop effective sustainable prevention and care policies and programs;

Ensure that persons with HIV and AIDS are always treated with dignity;

Provide compassionate health care and social support for persons with HIV and AIDS;

Strive to dispel irrational fears about HIV and AIDS in the military environment;

Recognize their capacity for care and prevention in both military and civilian communities; and

Participate in global HIV and AIDS research; and

WE COMMIT ourselves to the fostering of a spirit of cooperation and the sharing of experiences between military organizations and the communities in which they live and work in our common struggle against the HIV epidemic.

This statement was adopted by participants who organized the Civil-Military Alliance to Combat HIV and AIDS at a conference in Rockville, Maryland, USA, Nov. 20-22, 1994. The Consensus Statement originated at the Seminar on HIV/AIDS in Military Populations Around the Globe, Berlin Germany, 6 June 1993. Individuals came from the United Nations (UNDP, WHO) ministries of defense, military health organizations, national HIV and AIDS programs, bilateral donor organizations and others. Countries represented at the two meetings included:

Australia
Belgium
Brazil
Canada
Congo
France
Germany
Greece
Honduras
Indonesia
Italy
Kenya
Korea
Mexico
Morocco
Netherlands
Norway
Peru
Philippines
Portugal
Russia
Rwanda
Senegal
Switzerland
Thailand
Turkey
Uganda
United Kingdom
United States
Zimbabwe

Peace-time Threat? Security Threat?

The Military Importance of AIDS

Colonel Donald S. Burke, MD

Should a nation's military leadership be directly concerned with the global HIV/AIDS epidemic? Is the disease a threat to the accomplishment of a nations basic military mission: to defend its sovereignty and its national borders? Clearly the pandemic poses serious concerns.

Consider these questions:

■ Is HIV a peace-time threat? Yes. For nearly all nations of the world, the epidemic has a direct impact on the morbity and mortality of their personnel. Infection rates of any significance in a military setting have high price tags. Given lifetime treatment costs for patients and replacement costs for trained personnel, the total cost is extremely high.

In the US military, which began routine screening for HIV among active duty personnel in 1986, over 7000 Army, Navy, and Air Force men and women have been found to be infected. Most, if not all, will die from the disease. Rates of new infections among active duty forces have decreased substantially from a peak rate of over 1000 cases per year to the current rate of about 400 cases per year. Nonetheless, HIV/AIDS remains a major cause of mortality, albeit deferred mortality, among active duty personnel in the US military. The impact on reserve forces has also been substantial: over 4,000 guard and reserve have been found to be infected.

The total cost of the epidemic for the US military are projected to be between 1 and 2 billion dollars. These are reactive costs; pro-active investments in disease prevention have a high yield per dollar.

■ Is HIV/AIDS a readiness threat? Yes. In developing nations HIV/AIDS may well soon become a major readiness threat in that many highly-trained officers and noncommissioned officers are not available for duty. In the US and most western nations this is not an immediate problem.

Over the past decade approximately 4,000 civilian applicants for military service have been denied entry into active duty because they were found to be infected at the time of their entrance medical examination. Although HIV/AIDS is the leading cause of death in young adult males in the USA, the disease has not had a major impact on the military's ability to recruit and access new troops. It appears unlikely that HIV/AIDS would be a major problem in the event of a full mobilization today; but in some scenarios it might be a problem.

■ Is HIV/AIDS a threat in combat (a war-stopper)? No. Unlike other acute diseases, such as dengue, cholera, or malaria, HIV does not pose a serious threat to the effectiveness of troops in combat. Since the incubation period from initial HIV infection to disease (AIDS) is typically many years, even infected troops can function adequately; HIV/AIDS is not a "war-stopper". Nonetheless, HIV/AIDS can influence military operations. Troops deploying to high prevalence areas are often very concerned about becoming infected, and may avoid contact with blood or refuse blood transfusions.

■ Is HIV/AIDS an international security threat? Yes. As the epidemic continues to rage unabated, the true military significance of HIV/AIDS will be seen in its destabilizing influence on severely affected countries. In some regions of the world military populations are highly infected, which will result in a decimation of those forces. Loss of key leaders will also contribute to socio-economic disruption with possible military-political instability. Although HIV/AIDS may not be a "war-stopper", the disease may become a "war-starter" or at least a "war-outcome-determinant".

■ Is HIV/AIDS a national security threat? Yes. Although HIV/AIDS may not currently be a "war-starter", the disease may soon become one in some regions and be a major influence in how a regional war is determined. The importance of HIV/AIDS in the Rwanda crisis, both as a background factor in starting the conflict and an on-going issue in reconstruction, is a case in point.

For the US, national interests are clearly tied to global stability, and any serious danger to global stability also threatens US interests. Furthermore, virus strains in any part of the world today may explode in epidemic form in the USA anytime in the future. Some of these newly imported virus strains may be more virulent or more transmissible than the more familiar domestic strains.

Policy Options and Policy Concerns

What should a national military leadership do given the realities of HIV/AIDS and its likely impact on its own forces? Policy concerns and options:

•Prevention: Education against HIV/AIDS should be aggressively and continuously conducted in military populations. Every training program should include time for HIV/AIDS education. Condoms should be readily available. Most importantly, military personnel should be taught that irresponsible sexual behavior is not compatible with a responsible military career.

• Routine programs for early diagnosis: It is in the best interest of the individual, and in the best interest of the military unit, if each individual infected with HIV is diagnosed early. Data on rates of HIV infections, not just AIDS, must be collected and analyzed if fair and rational policies are to be implemented and evaluated. AIDS cases today are HIV

Continued on page 6

Publications

Recent Literature on Civil-Military AIDS Issues

Compiled by Robert Currie and Nancy Hazleton

The published literature on HIV/AIDS in military settings is relatively scarce, although in recent years research reports and other articles have begun to occur. A number of published abstracts have appeared in the Proceedings of the International Conferences (Yokohama, 1994; Berlin, 1993) and in regional conferences. The following abstracts were compiled form sources derived from the AIDSLINE Abstracts.The reports are divided geographically: I. Africa II. Americas, III. Asia and IV. Europe

I AFRICA

Quinn, T.C. "Population Migration and the Spread of Types 1 and 2 Human immunodeficiency viruses" *Proc Nat'l Acad Sci* USA. 1994 Mar 29; 91(7):2407-14

Nearly 3/4 of the sixteen million people estimated as infected with HIV-1 and HIV-2 live in developing countries. Major factors in dissemination are migration from rural to urban centers, and return, by poor, rural, young, and sexually active individuals, and internal disruptions due to employment changes, tourism, the drug trade, and civil wars. In sub-Saharan Africa between 1960 and 1980, centers with more than 500,000 inhabitants increased from 3 to 28, and more than 75 military coups occurred in 30 countries. These factors led to the spread of STDs and HIV locally, and large international movements of infected individuals spread the epidemic [outside the region]. Southeast Asia, the last region to be infected, has the greatest potential for rapid spread because of population density and inherent risk behaviors. Economic recession has aggravated transmission by increasing the urban population, poverty, and prostitution, disrupting family and cultural values, and decreasing standards of health care.

II AMERICAS

Kane, S.C. "Prostitution and the Military: planning AIDS intervention in Belize" *Soc Sci Med.* 1993 Apr; 36(7) 965-79.

Ethnographic rather than epidemiological concepts in studying first world militaries in third world countries provide more dynamic analysis for developing AIDS intervention models keyed to sexual transmission of HIV. In Belize, the social interface between military and sex workers takes two forms: "recognized prostitution," in health-regulated brothels, and "quasi-prostitution," in non-regulated bars and hotels. The two forms differ also in the ethnicity, national origin, and professional identity of the sex worker, and this social identity emerges as a crucial factor in understanding how public health information is incorporated by heterosexuals who put themselves at risk for HIV in different social contexts. Analysis shifts between personal and trans-national, and the possibilities for inter-governmental negotiations regarding AIDS policy are discussed.

Mapou, R.L., J.R. Rundell, G.G. Kay, and E.C. Tramont. "Relating cognitive function to military aviator performance in early HIV infection" *Vaccine.* 1993; 11(5): 555-9

Studies reporting cognitive changes due to early HIV infection have been controversial because typically sub clinical, not relating to daily occupational functioning, in which effects of changes may vary. This is important to military performance, where occupational demands cover a wide spectrum of complexity, especially in military aviation. To determine how performance may be measured empirically, the authors 1) look at studies at Walter Reed Army Medical Center (WRAMC) which have shown cognitive changes; 2) summarize presentations at a November 1990 WRAMC conference, "HIV and Military Performance: Assessment Methodologies; 3) describe research developing measures to detect cognitive differences in civilian aviators, relating it to HIV; and 4) describe a research program to examine the possible impact of HIV-related cognitive changes on military performance.

The Military Importance of AIDS

Continued from page 5

infections that occurred a decade ago; decisions based on AIDS case rates are decisions based on the past, not the future.

• Treatment and counselling: Military must take the lead in implementing fair and humane policies in dealing with HIV-infected personnel. HIV should be dealt with just as would any other medical condition. HIV is not a marker for any adverse social or behavioral problem; in fact HIV'infected personnel can and often are excellent soldiers. Medical treatment, preventive vaccines, and prophylaxis against opportunistic infections such as tuberculosis and others can extend the productive life of infected personnel.

• Cooperation with civilian health authorities. Military organizations can take a lead role in establishing effective HIV/AIDS control programs. Cooperation between military and civilian health and education organizations can be a valuable way to insure that not only military personnel, but their families and communities join together to combat HIV/AIDS.

• International cooperation. HIV/AIDS knows no boundaries, no sovereignty. Mankind, civilian as well as military should unite in international cooperation on improved prevention, research, and treatment.

From the US military perspective, HIV/AIDS is a serious problem requiring a forceful response. A cooperative world-wide military effort could be an important factor in successfully combatting the global epidemic. ❑

Ray, K., V. Lasley-Bibbs, J. Newby, E. Sharpe, and S. Blake. "Process evaluation of U.S. Army HIV education strategies." Int Conf AIDS 1993 Jun 6-11; 9 (1): 949

HIV testing and education have been mandated for all US Army personnel since 1985, but their effects have been little reported.A four-phase study is under way to evaluate education strategies. It will assess interventions for risk behavior change (Phase I), impact (Phase II), outcome (Phase III), evaluation and large scale replication (Phase IV). This study describes and reports on Phase I, in which 13 of the most promising prevention programs were evaluated using a written survey, interviews with staff, and non-participant observation. Special attention was paid to strategies for minority soldiers, who have been disproportionately affected by HIV. This phase concluded that a wide variety of prevention strategies are in effect, conducted primarily (92%) by civilian RN's. Although most programs (62%) report behavior change objectives, only 23% of the strategies were for risk behavior change, and no programs dealt specifically with minority behavior change. Current HIV education programs are directed toward increasing knowledge rather than changing risk behavior. This emphasis needs to be redirected, and data from Phase I are being used to design Phase II, the impact evaluation

Tramont, E.C. and D.S. Burke. "AIDS/HIV in the Military." *Vaccine* 1993; 11(5): 529-33

As an STD that infects blood and kills its victim, HIV infection has an impact on all aspects of military life. As lead agent for infectious disease research in the DOD, the US Army Medical Research and Development Command is addressing these concerns: surveillance of infection rates around the world and in the military (intelligence), behavioral research to develop education to change behavior, biological research to develop a quick and easy field test and a vaccine or drug to prevent infection in spite of exposure. The success of this comprehensive program will influence the effectiveness of the Army in the future.

Cowan, D.N., J.F. Brundage, and R.S. Pomerantz. "HIV infection among women in the Army Reserve Components." *J Acquir Immun Def Sydr*. 1994 Feb; 7 (2): 171-6

There is little information regarding the extent of HIV infection among women. Since late 1985, members of the Army Reserve have been routinely tested for HIV, permitting direct measurement of the relevance and incidence of infection in a military-associated population with limited military contact. The authors evaluated the prevalence among 122,195 women, and the incidence density among 96,001 women followed for 247,872 person-years. Overall prevalence was 0.65 per 1000, and the incidence density was 0.12 per 1000 person-years follow-up. Several demographically defined groups, including minority women, had elevated levels of infection. Comparison to the incidence densities of infection between early and late in the testing program showed no evidence of acceleration or deceleration.

III ASIA

Fernando, D.F. "The Civil War in the Northern & Eastern Provinces & STD & HIV infectivity in Sri Lanka" *Int Conf Aids*. 1993 Jun 6-11; 9(2): 677

Using data from the health ministry and other sources, the author explores factors influencing STDs and HIV in relation to civil war in the northern and eastern provinces. Since 1975, high employment in Sri Lanka has triggered labor migration to the Gulf States and back, and widespread tourist movement and drug trafficking has also taken place. The war has produced increased mobility in groups vulnerable to STD and HIV infection: military troops, refugees, and the Liberation Tigers for Tamil Eelam (LITE). Prostitution flourishes in the major towns, and estimates are that only 15-20% of STD infection is treated at government clinics. As of 1992, an estimated 2500 persons were HIV-infected. Because of the high priority given to the war and general financial restraints, inadequate attention has been given to STD and HIV infection and related health education.

IV EUROPE

Dmitriev, V.I. and T.N. Platonova. [The prevention of HIV in the army and navy]. *Vrach-Delo*. 1992 Nov-Dec (11-12): 104-6. In Russian. No translation.

In the course of five years, 121 foreign and 13 Soviet military servicemen showed HIV infection. Seven (officers and warrant officers) are still in service. As distinct from WHO requirements, symptomless virus carriers are also registered. Infected servicemen constitute 1.5% of the total number infected in the country.

The Civil-Military Questionnaire:

A survey of 90 nations and their policies on Civil-military prevention.

Because of the broad interest in issues of AIDS in the military and the seriousness of the HIV/AIDS situation, a questionnaire has been developed by the Alliance to survey a range of questions of interest to all members.

The questionnaire will be circulated in February 1995 to all nations who are members of the International Congress on Military Medicine. It was developed jointly by members of the World Health Organization's Global Program on AIDS and senior members of the Alliance. It is made up of 42 questions on four pages and includes questions on AIDS policies, education and prevention programs, testing and condom programs and care programs.

It is hoped that Alliance members will insure the questionnaire is completed in their own countries, and help circulate the compiled information. All country responses will be confidential and no individual country will be identified.

Call for Brief Articles

The editors of the *Alliance Newsletter* are seeking brief articles, news items, research reports, book notes and up-coming conference notes, to be published in future issues.
(April, July and October 1995)

TOPICS OF INTEREST

- HIV/AIDS Prevention in Military Settings
- Military Education and Training programs
- Research Findings on Civil-Military Aids Issues
- Issues of Families, Military Children, Child Soldiers
- Issues of Sex Workers in military communities
- Issues of Peacekeeping and AIDS
- Issues of Training in Pre-Deployment Briefings
- Issues of demobilization, AIDS prevention
- Bibliographies and Resource guides

Please send items to: The Editors, The Alliance Newsletter, c/o AIDS and Society,
4 West Wheelock Street
Hanover, New Hampshire, 03755 USA

AUTHORS' BIOGRAPHIES

Neal Boswell, MD, Colonel, US Air Force, is Director of Laboratory Sciences, Division of Retrovirology, Walter Reed Army Institute of Research, Rockville, Md. USA

Donald Burke, MD, Colonel, US Army is Director of the Division of Retrovirology, Walter Reed Army Institute of Research, Rockville, Md. USA.

Robert Currie is a writer and editor based in New York City and serves as managing editor of *AIDS & Society*.

Nancy Hazelton of the U.S. Public Health Service is concerned with international issues and a specialist in information exchange and communications.

Norman Miller, PhD, is Co-Director of the Alliance, a Professor at Dartmouth Medical School, and editor-in-chief of *AIDS and Society*.

Raymond Wouters, MD Lt. Colonel, is Director of the Belgium military HIV/AIDS clinic and a co-editor of the *Alliance Newsletter*.

CALENDAR 1995-1996

FEBRUARY 21-23 1995	YAOUNDE, CAMEROON **AIDS and the Military in Africa**
MAY (tentative)	BRUSSELS, BELGIUM **Civil-Military Alliance Regional Meeting**
JUNE (tentative)	SOUTHERN AFRICA **Regional Training Seminar WHO/World Bank/ Civil-Military Alliance**
JUNE 29	WASHINGTON DC, USA **National Council for International Health AIDS Conference Satellite**
AUGUST 7-9	WASHINGTON DC. USA **USAID: 3rd HIV/AIDS Prevention Conference**
SEPTEMBER 4-15	**BEIJING, CHINA** **UN 4th World Conference on Women: Action for Equality Development and Peace**
	(contact: S. Kindervatter, USA. Fax: 202-667-6236)
SEPTEMBER 17-21	CHIANG MAI, THAILAND **Asian Regional Conference on AIDS and Civil Military Training Seminar**
NOVEMBER 15-17	SANTIAGO, CHILE **Latin American Regional Conference on AIDS and Civil-Military Satellite Training Seminar**
NOVEMBER 26-30	JERUSALEM, ISRAEL **9th International Conference on AIDS Education**
	(contact: 972-3 660 325 or 972-3 517 5674)
DECEMBER 10-15 1995	KAMPALA, UGANDA **African Regional Conference on AIDS and Civil-Military Alliance Training Seminar**
JUNE 3-5 1996	BEJING CHINA **International Congress on Military Medicine**
AUGUST 7-10 1996	VANCOUVER, CANADA **XI International AIDS Conference**

Civil-Military Alliance to Combat HIV and AIDS

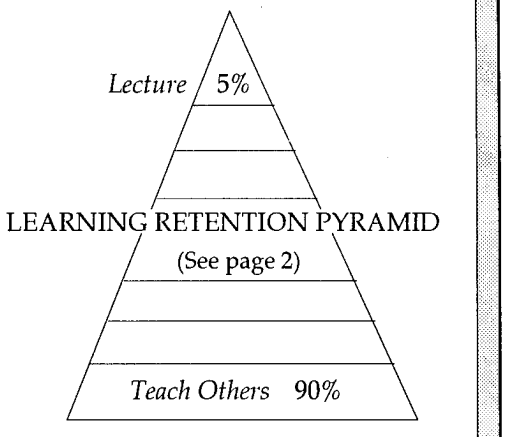
SUPPLEMENT "B"

RESOURCE GUIDE

Training Materials and Program Resources

Supplement • Volume 1, Number 3 July 1995

Contents



What Can Militaries Use in the Struggle Against AIDS?

Sven Groennings, Robert Currie

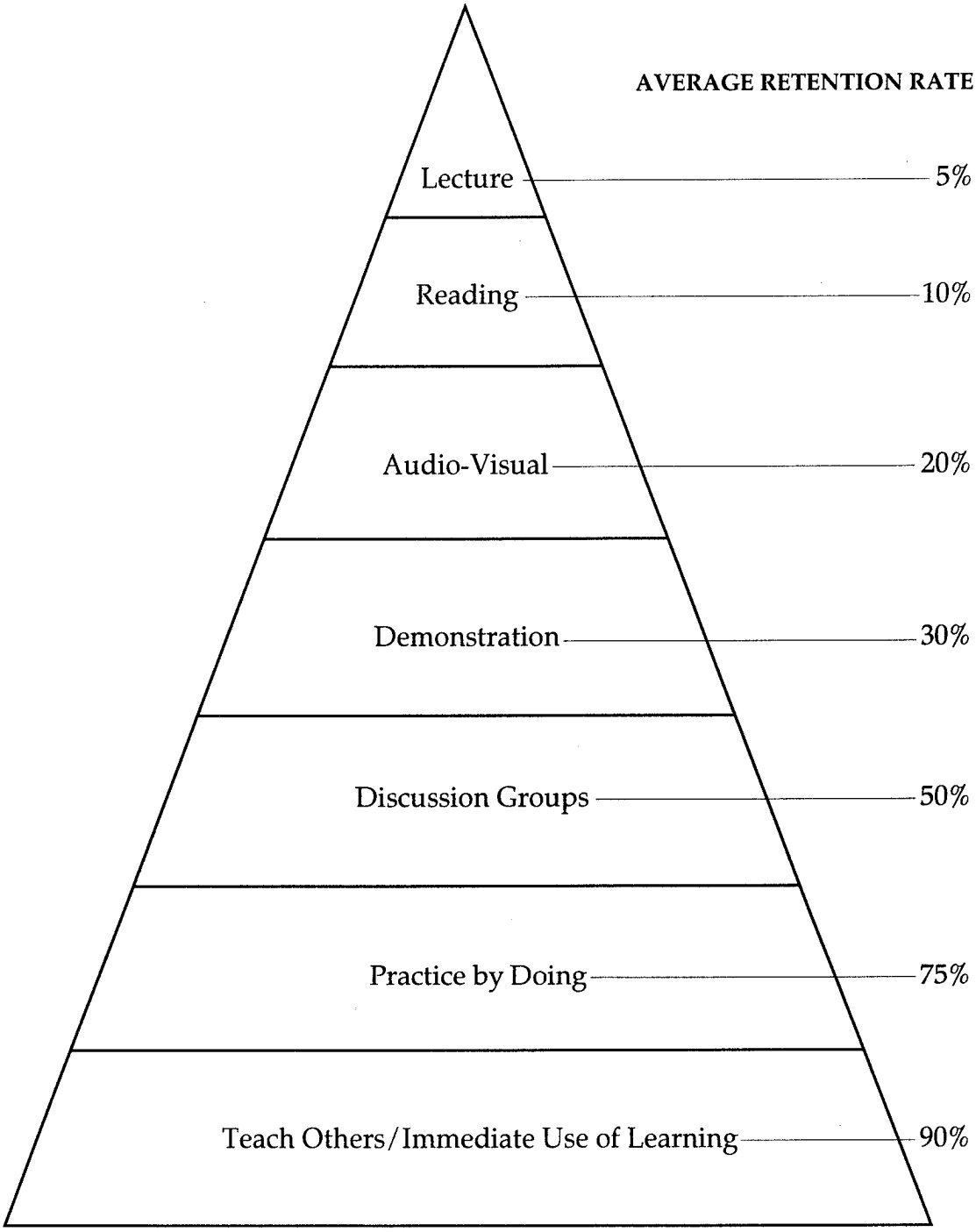
Unquestionably AIDS represents the most difficult non-combat training challenge military leaders can face. How to save new recruits or seasoned soldiers from death due to AIDS involves confronting a soldier's core beliefs and behaviour about sexual expression. Changing behaviour in young, vulnerable individuals can take years, even in problems, such as alcohol abuse or reckless driving where one's sexuality is not an issue

Training materials that are useful in military settings, or in situations where civil-military issues are being addressed are extremely rare. Some armies have created programs and published training guides, but there is little exchange of these materials and no central clearinghouse to turn to. This supplement is designed to provide information on those programs that do exist and to explain how some of them work. Some of the questions we have asked:

- Where can resource material about HIV in military settings be found?
- What training program examples are available?
- What are the essential requirements for training programs?
- What are the costs of developing such programs?
- Who can assist in developing such programs?

This supplement to the Newsletter represents the beginning of our research into this area. We plan to report on other materials that are discovered and welcome comments and information that can be of use to other instructors and trainers. ❑

LEARNING PYRAMID



How Do Trainers Train? How Do Individuals Learn?

Lectures by instructors or asking students to read specific material may be easy methods of teaching, but they are also the least effective techniques. Experiments in learning **retention** suggest that being forced to teach others, to use material in immediate, applied , practical ways and to "practice by doing" are the most effective training.

The learning pyramid above suggests retention rates of other techniques that are also more effective than lecturing. With audio-visual learning, demonstration, and discussion groups for example the average rate of information retention is between 20-50%. (Source: National Training Laboratories, Bethel Maine,USA)

Resource Guide

This section describes eight published guides that will lead the trainer or instructor to a wide array of materials useful in AIDS prevention programs.

Essential Aids Information Resources

(London and Geneva: Appropriate Health Resources and Technologies Action Group (AHRTAG) and WHO 1994, 35 p. Also in French (*Bibliographie selective sur le sida et l'education sexuelle*) and Spanish (*List a de recursos esenciales sobre el HIV/SIDA disponibles para su uso en America Latina y el Caribe*). Contains references to 125 sources, with addresses of suppliers, under six categories: books, training materials, teaching tools, videos, newsletters and journals, resource guides and catalogues.

Available from: World Health Organization Global Programme on AIDS, CH 1211 Geneva 27 Switzerland. *For Spanish language edition:* CRISSOL/Colectivo Sol, Apartado Postal 13-320, Mexico City, DF 03500 Mexico

Catalog Of HIV& AIDS Education and Prevention Materials.

CDC National AIDS Clearinghouse. (U.S. Department of Health and Human Services/Centers for Disease Control and Prevention, September 1994). 99p. Contains references to CDC published, videotape and poster materials as well as resources for research under three headings: prevention and risk reduction materials; materials for people living with HIV/AIDS and for caregivers; reports and statistics. Some materials are available in Spanish and other languages.

Available from: CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003

Information Resources in the Field of AIDS: European Seminar for the Creation of a Common Thesaurus

Paris, March 26-28, 1993. Centre Regional d'Information et de Prevention du SIDA. (Paris: Centre Regional, 1993, 110p.) A compilation of information resources on HIV and AIDS available at various documentation centers worldwide. It describes the services at each center, languages, subjects, classification schemes, lexicon or keyword lists, and indexes. Medical subject headings (MeSH) of the United States National Library of Medicine (NLM) are explained.**Available fom:* Centre Regional d'Information et de Prevention du SIDA 192 rue Lecourbe , Paris 75015 France

Aids & Mobility: Bibliography Of Publications About Travellers, Ethnic Minorities, Migrant Communities, And HIV/AIDS

European Project "AIDS and Mobility." (Utrecht, The Netherlands: National Committee on AIDS Control, February 1994), 67p. 302 references, briefly annotated, mainly on Europe but with references to all continents. We note: (1) that the "AIDS & Mobility" (A&M) documentation service will establish a database on projects specifically designed for mobile populations and that project descriptions will be published in late 1995; and (2) that A&M's purposes are also to build a network of organizations and to initiate and support HIV/AIDS prevention activities for travellers, migrants and ethnic minorities. A&M receives funding from the European Commission, WHO (GPA/EURO) and the Ministry of Health of the Nerherlands.

Available from: "AIDS & Mobility" Project, Dutch Centre for Health Promotion and Health Education A. van Ostadelaan 140, 3583 AM Utrecht, The Netherlands

AIDS Education in Asia and the Pacific Resources Directory: Organizational Profiles and Inventory of Materials

UNESCO Principal Regional Office for Asia and the Pacific. 2nd Edition. Prakanong, Thailand: UNESCO, January 1992, 61p. Lists organizations that are developing educational materials and programs related to HIV and AIDS and provides program information. Organizations listed are in Australia, French Polynesia, Hong Kong, India, Indonesia, Macao, Malaysia, Mongolia, Nepal, New Zealand, Philippines, Republic of Korea, Singapore, Sri Lanka, and Thailand.

Available from: United Nations Educational, Scientific and Cultural Organization Principal Regional Office for Asia and the Pacific, P.O. Box 967, Prakanong, 10110, Thailand

Bibliography

Center for AIDS Prevention Studies (CAPS). (University of California, San Francisco, May 1995), 55p. More than 800 references to publications and reports by CAPS staff under headings on overviews, access to care, policy, intervention evaluation, basic science, and methodological findings. These items are based mainly on American data, but some international.

Available from: Center for AIDS Prevention Studies, University of California-San Francisco, 74 New Montgomery St, Suite 600, San Francisco, CA 94105, Tel.: (415) 597-9100 Fax: (415) 597-9213

Evaluating HIV/AIDS Prevention Programs In Community-based Organizations

(Washington, D.C.: National Community AIDS Partnership, September 1993), 141p. Reviews reasons for evaluation; types of evaluation (process, outcome, formative, impact, cost-effectiveness, program implementation); data collection and research designs; and evaluating interactive small group interventions, one-on-one interventions, centralized information and referral programs, and media-based interventions.

Available from: National Community AIDS Partnership, 1140 Connecticut Ave., NW., Suite 901, Washington, D.C. 20036-4001

Resource Pack On Sexual Health And AIDS Prevention For Socially Apart Youth

Hand-in-Hand Network (AHRTAG and the Brazilian Center for the Defense of Rights of Children and Adolescents, 1993, 64p.) Global in scope, funding by WHO, this "resource pack" contains annotated lists of resources and contacts useful in focusing on youth in refugee camps as well as those who are homeless or otherwise "socially apart." Areas of interest to Network members include children in conflict/war and AIDS orphans. Included are 133 resources and 300 organizations, drawn from a database holding information on more than 700 organizations. Published in English, this booklet lists resources available in Spanish, French and Portuguese.

Available from: The Appropriate Health Resources Technologies Action Group (AHRTAG) 1 London Bridge St. London SE1 9SG, England *or* Centro Brasileiro de Defesa dos, Direitos da Crianca e do, Adolescente (SOS Crianca), Caixa Postal 4884, Ag. Central, CEP 20 100, Rio de Janeiro, RJ Brazil

Resources

This section describes five major resource centers that can provide assistance in locating materials useful in building prevention programs.

AEGIS: A GLOBAL ELECTRONIC CLEARINGHOUSE

In 1990, Sister Mary Elizabeth, a former US naval aviation electronics engineer, began AEGIS, the AIDS Education General Information System. Believing the best way to fight AIDS is to expand knowledge, she wanted information to be freely available, easily accessible, and widely disseminated. AEGIS has become Sister Mary Elizabeth's life work, her mission.

Today, AEGIS is a global freeway to people, knowledge and resources. It is the world's largest non-government database on HIV and AIDS, and is the cornerstone of the Global Electronic Network for AIDS, an international consortium, of electronic bulletin boards (BBSs). It regularly uploads information to more than 150 BBSs in North America, Europe, Africa, Asia and Australia. Also, AEGIS provides gateways to a number of AIDS-related conferences or "electronic town-halls" in English, Dutch, German and Spanish, where users can seek and share information. It is a global online network for communication about HIV/AIDS. For many, it is the best resource available.

The AEGIS database contains nearly two gigabytes (a gigabyte is 1,000 megabytes: a byte is the space taken by one character, such as a letter of the alphabet) of information, stored in over 159,000 files of information, with several hundred new files added monthly. Users can read and download more than 26 different full-text publications, the National Library of Medicine's Clinical Alerts, AIDS Drugs, AIDS Trials, and AIDSLINE databases (more than 100,000 files), the National AIDS Clearinghouse resource data (more than 15,000 files, a Law Library containing dozens of full-text AIDS-related judicial decisions and legal commentaries, a Funding Resource database, and a global events calendar. Users also can connect directly to the White House (ONAP/OASH) BBS, FDA BBBS, and NIH BBS in Rockville, Maryland.

AEGIS is accessible to anyone with a computer and a modem at any time from almost any place in the world. It also is user-friendly. AEGIS screens are easy to understand even by computer novices. Because AEGIS is "keyword searchable," topics can be found by typing in a few simple instructions. Sister Mary Elizabeth plans to put all of AEGIS on the Internet.

For its first five years, AEGIS has been free to the user and has depended entirely upon donations to operate. Because Sister Mary Elizabeth volunteers her service, her budget has been under $20,000. AEGIS will continue to make free access available to people with HIV/AIDS and the organizations that support them. For others, AEGIS has begun modest user fees in 1995 to cover half of its operating costs and enable it to continue its growth.

To use AEGIS, set your communications software to 8N1/Full Duplex and dial 714-248-2836. Address: AEGIS, Sisters of Saint Elizabeth. P.O.Box 184 , San Juan Capistrano, California 92693-0184 ❑

THE NATIONAL LIBRARY OF MEDICINE

With a collection of five million items, the National Library of Medicine (NLM) is the world's largest research library in a single scientific and professional field. Each year NLM fills more than 2.5 million interlibrary loan requests.

MEDLARS, the Medical Literature Analysis and Retrieval System, enables rapid bibliographic access. It is the database for *Index Medicus*, the monthly subject/author guide to articles in 3,000 journals. MEDLARS also represents a family of more than 40 databases which are available through NLM's online network of more than 100,000 institutions and individuals in the United States. This family of databases contains 18 million references and enabled 7 million searches in 1994.

This huge system includes a comprehensive AIDS information service which provides information on AIDS research, diagnosis, treatment, control, and prevention. As noted above, three databases — AIDSLINE, AIDSTRIALS, and AIDSDRUGS —are accessible through the AEGIS Global Electronic Clearinghouse as well as on the MEDLARS system.

AIDSLINE is an online computer file containing more than 100,000 references to the literature on HIV and AIDS published since 1980. More than half of these references have abstracts. The file focuses on the biomedical, epidemiologic, health care administration, oncologic, and social and behavioral sciences literature. It includes citations to research, clinical aspects, and health policy issues. It contains citations, with abstracts if available, to journal articles, monographs, meeting abstracts and papers, government reports, theses, and newspaper articles from 1980 to the present. AIDSLINE contains all abstracts of papers presented at the Fifth through the Tenth International Conferences on AIDS. Beginning in January, 1995, citations to articles from more than 20 HIV/AIDS newsletters are being added to the database. AIDSLINE is up-dated weekly. Approximately 1,000 new citations are added each month. Online access is free of charge. Access the database on MEDLARS by issuing a "FILE AIDSLINE" or "FILE AIDS" command.

AIDSTRIALS and AIDSDRUGS provide information on clinical trials of drugs and vaccines being tested against AIDS, HIV infection, and AIDS-related opportunistic infections. AIDSTRIALS reports the purpose of the trial, eligibility criteria, contact persons, agents being tested, and trial locations. In complement, AIDSDRUGS records information, such as pharmacologic action and contraindications, about each agent being tested in these clinical trials.

AIDS Bibliography is derived from AIDSLINE and is produced monthly, displaying references by subject and by author. You may order *AIDS Bibliography* from the Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. The GPO List ID is AID95. The yearly subscription price is $84 in the U.S., $105 foreign.

GRATEFUL MED is an inexpensive ($29.95), microcomputer-based software package, developed by NLM, that provides access to the MEDLARS system. It is available for IBM/compatible and Apple Macintosh personal computers.

Address: The National Library of Medicine, 8600 Rockville Pike, Bethesda, Maryland 20894 Telephone: AIDSLINE: 1-800-638-8480 AIDSTRIALS/AIDSDRUGS: (301) 496-3147 *AIDS Bibliography* and general reference questions: (301) 496-6095 or 1-800-272-4787 ❑

CENTER FOR AIDS PREVENTION STUDIES

CAPS, the Center for AIDS Prevention Studies, was established at the University of California, San Francisco, in 1986. With a staff of 40 investigators and a much larger support staff, CAPS conducts epidemiological and behavioral studies in the primary prevention and early intervention of HIV disease. CAPS also does ethical studies and policy analyses of AIDS-related issues. It has a strong commitment to multicultural inquiry and is concerned with cultural sensitivity and cultural competence in delivering HIV prevention services. It designs its studies for impact on practice and policy as well as to contribute to scientific knowledge.

Some of CAPS' work is international, notably research in Rwanda and Brazil and the behavioral research CAPS scientists are conducting in coordination with AIDSCAP/Family Health International prevention campaigns in several world regions. Its International Visiting Scholars Program brings scholars from Africa, Asia, Eastern Europe, and Latin America to San Francisco for training in conducting AIDS prevention research and to assist in developing research protocols. It provides technical assistance to these scholars when they return to their home countries to do their research. Address: Center for AIDS Prevention Studies, University of California-San Francisco, 74 New Montgomery Street, Suite 600, San Francisco, California 94105 Tel.: (415) 597-9100 Fax: (415) 597-9213 ❑

Resources

CDC NATIONAL AIDS CLEARINGHOUSE

Although there is very little literature — and no book — on HIV/AIDS in militaries, there is a massive general literature on HIV/AIDS. One can encounter much of a lot of it at the CDC National AIDS Clearinghouse in Rockville, Maryland, where there is a collection of approximately 20,000 items including 1,000 videotapes and 1,000 posters. There are 100 employees here. Some of them help the Hot Line, which operates on a 24-hour basis, answer 5,000-10,000 calls daily. The CDC Clearinghouse materials collection is rich in the Spanish language, and there are at least some items in 55 other languages besides English.

Along one wall there are 150 books on HIV/AIDS, related to care, prevention, drugs, blood transfusion, epidemiology, testing, homosexuals, women, hospices, the nervous system, nutrition, behavioral interventions, policy issues for health care and insurance, law, and socio-economic impacts. An impressive number of journals is publishing contributions to the literature, and there is of course the wider literature on tuberculosis and STDs.

The CDC is a good place, given the enormous size of the collection, to assess training materials in terms of their potential usefulness to militaries. In large part, the CDC collection of videos, printed training materials and policy documents focuses on schools and teenagers. Typically the American videos focus on late teenagers, of both sexes, in the same subculture, and on negotiating condom use. Most of this kind of material probably is not suitable to the older military personnel who are away from their home communities.

However, there also has been a large production of other kinds of materials. In the United States there are 17 regional AIDS Education and Training Centers, most of which have produced materials. There are training-the-trainers materials which vary in coverage and in the depth of medical detail. Perhaps the best, because it is especially thorough, is the Mountain-Plains Regional AIDS Education & Training Center's *HIV/AIDS Curriculum* (4th ed., 1992), which us used by the U.S. Air Force. Its modules cover such topics as Psychological Aspects; Ethical, Legal and Policy Issues; and Educational Methodology. They provide well-presented, in-depth knowledge to the trainer of trainers.

Also well-done is the New York State Department of Social Services' *AIDS Trainer's Guide* (1987). It is loose-leaf and designed for a three-hour session. Accompanying it is a much larger *Resource Manual* with sections on Medical Aspects, Psychosocial Implications, and Safety Implications, among others.

AIDS-in-the-Workplace is a theme area pertinent to militaries. Excellent materials have been prepared for the business community. One of every 250 Americans is HIV-positive, and one of every 10 businesses is affected. CDC supported the development of a very attractive boxed kit, *Business Responds to AIDS: Managers Kit.* It is most appropriate for corporate human resource professionals who are concerned with policy as well as program development. The kit addresses policy functions, policy models, corporate programs, principles for the workplace, how to implement a program, and the framework of laws providing for Social Security/Medicare/Medicaid and the Americans with Disabilities Act. The kit sets out to answer these questions: What does an employer need to know? What does a program cost and how do you offer it? What are the insurance issues and treatment costs? How do you provide an education program? What should corporate policy address?

The CDC Clearinghouse Database can produce lists of resources, often annotated, by topic. Thus one can collect references on a country or on economic impact generally. A search under "Military" confirms the paucity of the literature. However, one will find the ways in which the world and American press reports news stories about the military and HIV, for example, when there are court cases, port visits overseas, or controversial issues of military policy. Perhaps reviewing this material is good preparation for becoming a military press officer. ❑

[Contact: CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, Maryland 20949-6003. Fax: 301-251-5343]

CANADA: CLEARINGHOUSE AND AFRICA PROGRAM

The National AIDS Clearinghouse, Canada's documentation center for HIV and AIDS educational information, is bilingual in its services, providing information in both English and French. It has a significant collection of Spanish-language materials as well.

The Clearinghouse supplies free materials for educational programs. It receives hundreds of requests every week from schools, hospitals, support groups, trade unions, private sector employers and others. All its services are available to the Canadian armed forces and have been accessed by military personnel from all across the country.

The Lending Collection contains over 12,000 items in 80 languages. Every item in the collection is catalogued in the Clearinghouse's databases, which the staff search to identify the materials best suited to those making requests. Only about one-third of these items are Canadian in origin, and the Clearinghouse does not seek to duplicate extensively collections to which it has easy access in the United States. It is building a broadly international collection. It collects materials from other countries as examples of different approaches in the AIDS education field.

The Distribution Collection contains more than 200 titles of documents for free distribution, produced by more than 25 different agencies. Some of the manuals, for example *Responding to diversity: a manual for working on HIV/AIDS issues with ethnically diverse communities,* are complimented by booklets and pamphlets such as *Caring safely for people with HIV or AIDS* and *HIV/AIDS discrimination: it's against the law.* There are posters also.

All items are available on loan directly to Canadian agencies, and through interlibrary loan to private individuals. In addition to the *National AIDS Clearinghouse Catalogue,* there is a *Video and audio: Loans guide. Canadian AIDS News (CANews),* a free bimonthly periodical, is circulated in 11,000 copies.

Available from: National AIDS Clearinghouse, Canadian Public Health Association, 1565 Carling Avenue, Suite 400, Ottawa, Ontario Canada KIZ 8R1 Tel.: (613) 725-3769 Fax: (613) 725-9826 ❑

The Southern African AIDS Training Program (SAT)

In Africa, Canadians have created a cost-effective, major program which may be considered a world model for building capabilities. The purpose is not to train-the-trainers, an approach whose effectiveness may weaken as each new tier of trainers is added, but instead to build networks of organizations which together improve their ability to deliver effective HIV/AIDS prevention and care programs after those trained return to their sites.

The emphasis is on peer education, skills clinics, mentoring relationships and apprentice placements, sharing best-practice innovations, tailored site visit tours, all in the context of partner organizations. The overall program is called the School Without Walls.

Partners include AIDS service organizations, hospitals, religious groups, trade unions, youth organizations, adult education organizations and professional associations. There are more than 100 project partners. Some projects are implemented jointly by NGOs and local government departments. Many project partners work in cross-border areas where there are high concentrations of travelers, migrant workers, traders and others likely to be HIV-vulnerable. One peer education network, for example, is along a major transport route crossing Zambia. Another crosses Zimbabwe's eastern highlands into Mozambique's central corridor.

The Southern African AIDS Training Program (SAT), funded by the Canadian Public Health Association (CPHA), provides flexible funding, project design assistance, and links to experienced sister organizations in such theme areas as peer education, community care and counseling, and youth work. With headquarters in Harare, SAT covers 10 countries.

Addresses:

Southern African AIDS Training Programme (SAT)
PO Box 390
Kopje (4 Beit Ave., Milton Park)
Harare, Zimbabwe
Tel.: (263-4)723-915 Fax: (263-4)725-193

SAT Programme
Canadian Public Health Assn.
400-1565 Carling Avenue
Ottawa, Ontario
Canada KIZ 8R1
Tel.: (613) 725-3769 Fax: (613) 725-9826

This section describes six training programs that have either addressed HIV/AIDS in military population directly — as the three U.S. military programs — or have had components useful to military trainers.

AIDSCOM: LESSONS LEARNED

AIDSCOM was a $24 million, six-year project (1987-1993) of the U. S Agency for International Development (USAID) awarded to the Academy for Educational Development (AED). It involved more than 50 countries in Africa, Asia, the Caribbean, and Latin America. AIDSCOM's objectives were to increase knowledge and understanding of behavior change for HIV prevention, develop effective prevention methodologies, and strengthen local organizations in their use of modern communication for HIV prevention.

Distinctive features of AIDSCOM's work included a major research agenda and numerous innovations in pursuit of demonstrably effective strategies. Informed by behavior change theory, i.e. the Applied Behavior Change (ABC) Framework, AIDSCOM was attentive to its research agenda from the beginning and tested a variety of pioneering approaches. AIDSCOM provided technical assistance for large-scale KABP surveys assessing the knowledge, attitudes, beliefs and practices of general populations and high-risk groups. It used KABP surveys to inform intervention designs and as baselines for follow-up surveys used to evaluate interventions. It monitored and compared each country's programs. Interventions address social norms and skills in HIV prevention.

Research was an aspect of all its categories of interventions to effect behavior change: counseling skills, women's programs, working with South African traditional healers, mass media campaigns, AIDS-in the workplace training, interventions with homosexuals and sex workers. Systematic planning led to integrated strategies. AIDSCOM conducted more than 80 behavioral research studies.

AIDSCOM had significant catalytic effect by establishing relationships with more than 75 NGOs and CBOs worldwide; initiating 10 national AIDS hotlines; beginning AIDS-in-the-workplace training, most notably in Uganda; producing 12 training guides, conducting 275 conferences and stimulating five national AIDS communication campaigns.

AIDSCOM used third-country nationals as regional consultants. Its mass media campaigns ranged from the Grim Reaper campaign in Australia, exemplifying the scare technique, to Ghana's "Don't Be Careless, Get Protection" to "It's Not Easy," Africa's first film-length drama about AIDS which was developed in connection with the Ugandan workforce program. AIDSCOM distributed nearly 2,000 copies in 56 African countries, and "It's Not Easy" has been broadcast also in Jamaica. French and Swahili versions have been made.

One of AIDSCOM's purposes was to provide information about strategies that work. It has produced several publications on the general and program-specific lessons learned. The most generally useful of these are *A World Against AIDS: Communication for Behavior Change* . (Washington, D.C.: AED, November 1993, 285 pp.) and the much smaller companion volume, *Partners Against AIDS: Lessons Learned,* 128pp. There is also a program development guide, *Controlling AIDS Through Health Promotion,* I02pp., and there are loose-leaf field notes on lessons learned. Available from: Academy for Educational Development, 1255 23rd Street, N.W. ,Washington, D.C. 20037 Tel.: (202) 884-8882 Fax: (202) 884-8713 ❑

RED CROSS TRAINING PROGRAM: "Best of the Best" in Pan American Region

The American Red Cross has developed an excellent, widely-admired training program which has been adopted by the U.S. Navy as well as by national Red Cross programs in several Latin American countries. The relevance of the American Red Cross program for Latin America stems from its having created a Hispanic Program for Spanish-speaking people within the United States, which has one of the Western Hemisphere's largest Spanish-speaking populations.

Given the quality, availability, and low cost of the program, there is no need to begin de novo in program development. Red Cross materials in English and Spanish, which are easily translatable into other languages, have gone through several stages of field-testing and revision. There is a wide range of instructional materials including instructional charts, materials to train trainers, pamphlets, posters and videos. These are well-coordinated. For example, for the *Mi Hermano* booklet for course participants, there is an accompanying video.

The booklet *Prevencion del HIV/SIDA para la Familia,* which is available also in English, is similarly excellent. The instructional charts, guiding presentations, are superb. Much of the Red Cross pedagogical philosophy is based on the work of Brazilian educator Paulo Freire, who emphasized plático or dialogue — participatory learning. The Centers for Disease Control (CDC) has provided financial support for program development. The American Red Cross training model features careful quality control at each level, and produces multiplier effects quickly. The illustration shows the three levels of trainers and the chain of multiplier effects:

Master Trainers/ National Faculty train those who will prepare the Instructors of Trainers. The number certified bilingually in both English and Spanish is now 17, including several in Puerto Rico. Five of them have been called upon to train trainers in Latin American countries. These American Red Cross National Trainers serve as "sellers," explaining the whole program as they enter a new country or start a major new program. They are volunteers, not full-time salaried personnel. All American Red Cross national faculty receive 60 hours of training.

Instructor Trainers take a week-long course. They are trained in pedagogy, multi-media approaches, skills development, and in encouraging participants' involvement in the learning process. Instructor trainers are essential to producing instructors; they are the key instruments of the multiplier effects.

In the American Red Cross' Hispanic Program, Instructor candidates pass two levels of tests. First they must pass two tests, each based on a four-hour program: one is a "Starter Facts" knowledge test, the other a "Facts Practice" test. Candidates next proceed to a 24-hour program on "Fundamentals" and a program of comparable length on "Prevention Skills," each ending with a written test and teachback. Trainers are prepared in groups of 20. Two Instructor Trainers work together to prepare the trainers. They look for possible candidates to receive higher-level training as Instructor Trainers. This recruitment builds the multiplier effects.

In the Red Cross experience, success has several requirements. There must be: (1) an authoritative commitment to action; (2) a plan with time-lines; (3) a program leader who will organize people, obtain the needed materials, master the logistics and meet schedules; and (4) an understanding of the need for levels of training as essential for building internal capacity and for quality control. The success of the program depends above all on selecting the right people. Costs are modest.

The Red Cross has conducted training programs for at least half a dozen U.S. Federal departments and agencies, including the White House staff. Red Cross programs may be tailored at every level for special audiences. In programs for militaries, there can be supplementary sessions on military epidemiology and policy. Red Cross adaptations for private industry have included features for hospitals and for the National Restaurant Association. Materials for African-Americans have been created with an ethnic perspective, with sensitivity to their health cultures, and utilizing culturally-relevant proverbs and artistic illustrations.

In South America, national Red Cross programs have been developed in Argentina and Colombia. The Argentine Red Cross prepared Instructor Trainers, Trainers, and activity reports. In Colombia, in parallel, the Ministry of Health and Cruz Roja Colombiano, assisted by the American Red Cross and the Fogarty International Training Program, developed programs in the ten most infected provinces. A final report was prepared December 15, 1994. In this project, the national coordinators prepared 80 professionals who trained 1,600 community leaders, who in turn reached 160,000 people. In Central America, El Salvador will be gaining 14-16 Instructor Trainers in 1995, and an additional military hospital. The American Red Cross program also has entered Costa Rica, Guatemala and Panama.

When one considers the magnitude of Latin America, the programs associated with the American Red Cross are very small. However, they are positive beginnings, the materials are excellent, some trainers have been prepared, feedback has occurred, and there now is potential for rapid expansion. ❑

[Contact: American Red Cross, HIV/AIDS Program, 8111 Gatehouse Rd., 6th Floor, Falls Church, Virginia 22042. Tel: 703-206-7637 Fax: 703-206-7754]

U.S. AIR FORCE TRAINING MODEL

In the late 19S0s, when the early cases of HIV became evident, the military confronted a new kind of problem. Base commanders had no management experience with this disease, military hospitals had not been treating AIDS patients, counseling was in its infancy, and prevention programs had not yet begun.

For the U.S. Air Force, the problem was real, but it was not major.

There were fewer HIV cases than in the Army or Navy, and the incidence rate was also lower. With 400,000 total personnel, the number of new cases yearly was in the range of 35 to 40, and the incidence rate is now declining. As policy, the Air Force committed itself to creating a prevention program at very low cost. Its program is en route to becoming available at all of its bases, but participation in it is not mandatory for all active-duty personnel. The Air Force conducts a train-the-trainer course at one site, Wilford Hall Medical Center at Lackland Air Force Base, San Antonio, Texas. Each base sends to Wilford Hall, at its own expense, a group of four people who are to become a local HIV Resource Team (HRT): a physician, a nurse, a dentist, and a military public health officer. They take a rigorous, comprehensive basic course toward enabling them to tailor their own program suitable to their base. During their training, they spend 10 hours together to develop their program. When they return to their base, they seek their base commander's approval of their proposed program.

The train-the-trainers program has been extended to 5 days. On the final day, the participants present and discuss their plan for their base. Earlier in the week they will have attended sessions on the team concept, needs assessment, prevention, care, behavioral research and behavioral change, education, planning, counseling, risks to health care workers, policies, legal aspects, and program evaluation. Some lecturers may be from already established programs at other bases. Each participant becomes familiar with the interactive videodisc (IVD) education programs on HIV/AIDS which have been created for the American armed forces (see article on page 12). Each also receives the comprehensive HIV/AIDS Curriculum manual prepared by the Mountains-Plains Regional AIDS Education & Training Center, a civilian resource center. In addition to the in-depth reference manual, each receives a didactic program to help in the participant's role as instructor.

Those who complete the Wilford Hall training are to provide HIV education and prevention training on their home bases, train other personnel to train additional personnel, integrate education/prevention into routine care, and help colleagues gain knowledge, skill and sensitivity in treating people who have HIV disease. They are to be able to utilize the principles of adult learning and group process in implementing their program. They are also to create an awareness of how society deals with contagion, stigma, disability, death, social stratification, and access to scarce resources. Most importantly, they are to focus on strategies that will facilitate change in risk-associated behavior. Mainly they address general military audiences, STD clinics and supervisors, but they also have provided education for youth and school programs and for public safety and health care workers.

The course has evolved from early emphasis on health care to preparing participants to become trainers and toward an emphasis on prevention. Supervisors receive more content on workplace policies while healthcare providers spend more time on medical care and risk reduction.

A significant problem is the turnover of team members as they take new assignments. It is necessary to renew the teams by training more personnel. At some large bases, the teams have been expanded on site.

In the three annual courses to date, 1992-1994, 300 health care providers have been trained as trainers, representing 87 bases. The annual central program cost, including $6,200 for supplies and $7,400 for speakers, is $17,000. ❑

[Contact: U.S. Air Force, HIV Programe, 59 MEDK/PSMI, 2200 Bergquist Drive, Suite 1, Lackland AFB, Texas 78236. Fax: 210-675-0173]

THE U.S. NAVY TRAINING MODEL

The U.S. Navy training program to prevent HIV infection, based on that of the American Red Cross described on page one, and conducted in collaboration with the Red Cross, has important implications for the militaries of other countries:

(1) Training of large numbers of personnel can be accomplished in a relatively short time; the greater the initial number of instructor-trainers, the faster the gain in multiplier effects.

(2) The crucial elements are leadership and commitment, not cost of materials.

(3) Militaries need not create the training materials, as those provided by the Red Cross and other organizations are excellent; modules can be added for military epidemiology and policy, etc.

(4) Certification of instructors is motivating and ensures high standards.

(5) Certified military personnel can be helpful in training civilian populations.

Finally, and most importantly, the Navy's training program has proved that civilian-military collaboration in training military personnel can be effective.

Let's look at the background of this program. The Navy planned a comprehensive program to reach all of its personnel. This was a formidable task, as there were 900,000 active duty Navy and Marine Corps personnel when the program began nearly four years ago. Even following subsequent force reductions, there still are 700,000 military and 200,000 civilian personnel. Because these militaries are very decentralized organizations, it was necessary to develop a training system that would reach 6,000 Navy units and 4,000 Marine Corps units. Training would have to be at the unit level.

In its initial assessment, the Navy estimated it would need one instructor for every 500 to 750 active duty personnel, accordingly requiring 1,000 active instructors. These instructors were either to be volunteers or on collateral duty assignments. The crucial success factors were understood to be leadership commitment and instructor quality. Logistics have not been much of a problem. Training materials have been a relatively minor cost, in the range of $50-$75 per instructor depending on the published and video materials provided to the instructors. The instructors receive Red Cross manuals and materials, plus additional Navy-specific training materials.

Instructors have been trained at five sites, including one outside the U.S. in Naples, Italy. As instructor-trainers, i.e. educators of instructors have been trained, the production of instructors has increased sharply. There are 50 instructor-trainers, and the cumulative number of Navy HIV Instructors trained exceeds 1,600. Nearly 90 percent of the current Instructors are active-duty personnel; most of the others are civilian Navy personnel while some very few are Red Cross. The percentage of non-medical personnel among the Instructors, now approaching 50 percent, has been growing steadily. In general, the Instructors are senior enlisted personnel, plus a substantial number of junior officers. The distribution by race or ethnicity is approximately proportionate to the Navy and Marine Corps as a whole.

Instructors receive dual certification, from the Navy and from the Red Cross. To be certified, candidates must pass one oral and three written examinations. Training is usually off site, e.g., at a Red Cross site, and some of the Navy personnel have volunteered to serve as Instructors for Red Cross civilian groups.

Instructors complete a 32-hour course: a four-day, eight-hour per day program in which there are two Instructor-Trainers per class. The Instructor Course includes discussions of principles of adult learning; HIV epidemiology in the military; testing, virology and immunology; psychosocial issues; military policy; and training using Department of Defense Interactive Video Disks developed for HIV education. This course is highly participatory, with a trainer-candidate ratio of 1:6. The final sessions are used for practice teaching. Approximately 85 percent of the candidates complete the course. To date, there have been approximately 150 Navy HIV Instructor courses.

In 1994 the Instructors provided training of one to two hours to 650,000 Navy and Marine Corps personnel. The training has progressed from providing information to skill-building toward practicing safe sex. Because of these accomplishments, and for the relative ease, economy, and effectiveness of training large numbers in a short time, the U.S. Navy program merits careful scrutiny and consideration by other organizations. ❑

[Contact: U.S. Navy Medical HIV Program, Box 219, NNMC 8901 Wisconsin Avenue, Bethesda, Maryland 20889. Fax: 301-295-5021}

INTERACTIVE VIDEODISCS FOR MILITARY TRAINING

In 1988 the U.S. Congress appropriated $9 million — $3 million each to the Army, Navy and Air Force — to develop an interactive videodisc (IVD) education program on HIV/AIDS. The project was managed through the Henry M. Jackson Foundation for the Advancement of Military Medicine. The project was completed in 1992. All three military services have the IVD products.

There are four separate IVD programs, of varying numbers of components, for: (1) STD clinic patients; (2) the general military population; (3) supervisors; and (4) medical personnel. In complement to these four "primary" programs are four knowledge assessment programs which test the learning and reinforce the skills and concepts taught in the primary programs. These knowledge assessment programs are designed in quiz format. The orientation of the IVD is toward heterosexuals.

Obviously, this is a very expensive program. Producing an IVD may require many months of filming, editing, acting, and duplication. The cost of the four-sided program for the "General Military Population" was $1.4 million. The knowledge assessment products, each consisting of four 30-minute discs, cost about $125,000 per product. In total, approximately $3.7 million was spent for program development and delivery, and about $4.1 million for IVD equipment.

Before this money was spent, there was a needs assessment to determine the target groups that should receive HIV/AIDS training, their training needs, and the availability of IVD user equipment.

Given the availability of this innovation, one may wonder about its effectiveness.Experts consider the quality very good. These IVDs are easy to use, and are being used in the context of an American culture that has evolved toward general acceptability of computers, video games, and videodiscs. User reaction is favorable. The IVDs are a useful extension of other training. Moreover, they can be used independently. However, two conditions are basic to their use. First, there has to be broad awareness of their availability. Second, the equipment must be dedicated to this particular function and be located conveniently in a private room where the audio component will not disturb others. Such places can be difficult to find. The basic weakness of IVD is not quality and not the skills of the potential users; it is in assuring the right conditions for utilization. ❑

FOGARTY INTERNATIONAL TRAINING

In Latin America, The Fogarty International Training Center Program at the University of Miami, funded by the National Institutes of Health, collaborates with the Red Cross. Fogarty pays the travel and materials shipment costs for Red Cross trainers traveling to Latin American countries, plus a consulting fee of perhaps $150 per day. These countries include Argentina, Colombia, Costa Rica, El Salvador, Guatemala, and Panama. Also, Fogarty brings Latin American and other foreign medical workers to the University of Miami to provide training pertinent to HIV/AIDS and other diseases. Participants undertake research, for which they receive small initial grants of perhaps $5,000. Fogarty also sends faculty to teach in Spanish in Latin America. The Fogarty Program, which began seven years ago, requires the filing of reports on projects it supports.

Overall, the Fogarty Program has three purposes:

- To increase the capacity of foreign scientists to deal with the AIDS epidemic through epidemiolgical research, clinical trials, and other prevention programs.
- To support collaborative research between the U. S. and foreign scientists in the epidemiology, diagnosis and treatment of AIDS.
- To stimulate cooperation and sharing of research knowledge by scientists combatting AIDS worldwide.

Fogarty has been host to trainers from the Czech Republic and Slovakia. There is particularly strong potential for Fogarty to expand its training of trainers for Latin America, including potential for working with trainers of Latin American militaries. ❑

Civil-Military Alliance to Combat HIV and AIDS

Alliance NEWSLETTER

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Asia

Six-Nation Meeting on Military AIDS Prevention

Stuart Kingma

Delegations from six countries of South and South East Asia met in Cha-Am, Thailand, in September 1995 for a four-day Regional Seminar on "AIDS Prevention in Military Populations". The seminar was designed to examine a number of policy issues and technical aspects important for the development of effective AIDS prevention programs — within the military, and to discuss how these efforts within the armed forces could be better coordinated with their own national (civil) AIDS programs.

As was the case for the earlier Regional Training Seminar for Eastern and Southern Africa, the gathering was financially supported by the Economic Development Institute of the World Bank, with content and planning input by the Civil-Military Alliance to Combat HIV and AIDS, WHO's Global Programme on AIDS (GPA), the Joint UN Programme on HIV/AIDS (UNAIDS) in consultation with the United Nations Department of Peace-Keeping Operations.

The delegations to this seminar represented the countries of Bangladesh, India, Indonesia, Malaysia, Nepal and Thailand. Once again the high-level delegations included officials from the Ministries of Defense, the military medical and nursing services, and the civil national AIDS programs.

The participants felt the HIV/AIDS epidemic posed a challenge to all, even those countries presently reporting a low HIV prevalence. They felt this encounter offered them an exposure to and examination of policy issues in a new light as perceived and expressed in their neighboring countries. It was a chance to exchange and learn from policy views and program approaches that would benefit their own policy reflection in the future.

They further realized that, although they had begun with widely varying experience and policy approaches, they had quickly come to a consensus on many issues, and this would lead them to review their policies and practices on their return home. They affirmed they had learned much from each other, and that this kind of shared policy reflection should become a continuing element in their own national civil and military health program development. (See report, p.10.) ❑

The Broader Context

New, Emerging and Re-emerging Diseases

A new initiative at WHO is addressing a broad spectrum of new and re-emerging diseases. Ebola, Dengue, Legionnaires Disease, Plaque and Meningitis are are examples of diseases that are re-emerging in strength. In addition to the emergence and re-emergence of new diseases, for which their is no cure, increasing resistance to antimicrobials will be a major cause of re-emerging bacterial and parasitic diseases.

Dr. David Heymann, Director of a new Division at WHO dealing with these issues, provided a briefing for the Alliance Steering Group recently in Geneva, seeking ways in which his organization and the Alliance could cooperate.

Some of these common concerns include the need for disease surveillance, including the use of military medical personnel for early warning in their regions, the need for regional laboratory support, and the need to cooperate promptly on logistic problems in an infected area.

In addressing the issue, Dr. Heymann noted, that "during the past twenty years the world has clearly been given a series of warnings about new and re-emerging communicable diseases and antibiotic resistance...currently some 29 new diseases have emerged, including Hanta Virus Pulmonary Syndrome and Hepatitis C, the later placing between one and two million chronically infected Americans at risk of disability and premature death. At the same time, other microorganisms may be waiting to bridge the gap from nature to man, to appear as newly emerging diseases."

WHO, with the Centers for Disease Control and Prevention in the USA, and other international collaborators took the lead in the Ebola Hemorrhagic Fever outbreak in Zaire during 1995. Part of the reason for the success in containing that epidemic lay in the ground work done by WHO in Zaire. Also, because of relations with ministries of health in its member states, WHO has been able to facilitate the necessary national clearances to arrive on sites quickly, to collaborate with and trained national staff, to strengthen and/or develop surveillance systems and laboratory support.

Collaboration with national and international partners during outbreak situations has also been possible with state of the art communications equipment, particularly in diffusing valid information worldwide, which helps governments make rational decisions about international precautions. This is particularly important for new epidemics that quickly cross national borders.

The Alliance has an informal study group headed by General D'Amelio of Italy, looking into ways that further cooperation in this sector could be initiated.

(Contact Dr. D. Heymann, Director, Emerging, Viral and Bacterial Diseases Surveillance and Control, WHO, 20 Avenue Appia, Ch 1211 Geneva, 27 Switzerland.) ❑

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News and Notes should be sent to:

Civil-Military Alliance Newsletter
4 West Wheelock Street
Hanover, NH 03755 U.S.A.

Tel: (802) 649-5296
Fax: (802) 649-2331
Telex: 4930372 RPC UI

NEWS BRIEFS

BOTSWANA—ACT (AIDS Action Trust) is a new Botswana NGO based in Gaborone that provides AIDS education and Prevention activities and information for those concerned with prevention including military personnel. (Contact: Semakaleg Kgaswane, ACT, 390 Independence Ave., Private Bag 00346, Gaborone. Tel: 267 314635, Fax: 267 314634)

BURMA— At an international conference on AIDS in Asia and the Pacific, the WHO estimated at least 400,000, or one percent of Burma's citizens, are infected with HIV. The high number of injection drug users, social tolerance of prostitution, and large cross-border trade with nearby nations were cited as contributing factors. The WHO spokesman noted that condoms are costly and rare in Burma. The international community was urged to end a ban on foreign aid to Burma, particularly humanitarian assistance.

INDONESIA—Treating HIV and AIDS will cost Indonesia up to $2 billion by 1999, the official Antara news agency has reported. "If the spread is not checked now, the consequences...will bring great loss to the national economy," Azwar Anas, coordinating minister for welfare, said. He also said there were 309 known cases of HIV/AIDS in the country. The World Health Organization, however, last year estimated there were 50,000 HIV-infected people in Indonesia, the world's fourth most populous nation. Nafsiah Mboy, an official of an Indonesian commission to coordinate efforts to fight AIDS, said that HIV has spread to most of the country's 27 provinces. Reuters (06/14/95).

KENYA—*The Daily Nation* reports one in seven residents of Nairobi, is infected with HIV. Communications consultant Raphael Tuju advised the Insurance Institute of Kenya that 14 percent of the capital city's population was HIV-positive. With 20 percent of the country's military infected with the virus that causes AIDS, Tuju urged insurance companies to initiate AIDS awareness programs.

Angola: 20 Years of Fighting

"A Lethally Perfect Petri Dish for HIV"

According to WHO's Dr. Ben Moussi, Angola is not prepared for the disease "psychologically, physically, [or] economically," thousands of international troops and aid workers, are at risk. The Center for International and Strategic Studies says the soon-to-be demobilized government and UNITA rebel troops pose the greatest threat: the infection rate is so high among African soldiers that they have a greater risk of dying of AIDS than from warfare. It is estimated that at least 100,000 Angolan and rebel troops — half of the fighting force — are infected with HIV. (*Washington Times*, 7/06/95)

SRI LANKA—The Tamil Tiger guerrilla stronghold of Jaffna in northern Sri Lanka has recently diagnosed its first case of AIDS, residents said. A 38-year-old migrant worker, who had recently returned home to Jaffna on vacation after eight years in Mexico, was found to have the disease after he became ill and was admitted to a hospital one week ago. The detection of the first AIDS case was reported by the "Voice of Tigers," the clandestine radio station operated by the Liberation Tigers of Tamil Eelam rebels, who are fighting for an independent homeland for minority Tamils in north and east Sri Lanka. Reuters (06/05/95)

ZAMBIA—Zambia has one of the highest number of recorded cases of HIV infection in sub-Saharan Africa, with 30,000 cases diagnosed. A 1993 Ministry of Health study revealed 16 percent of prison inmates infected with HIV. To limit the spread of the epidemic, 100 HIV-infected Zambian prisoners have been liberated, "because prisons are not places for keeping terminally ill people," said a Department of Prisons spokesman. Homosexuality (sic) and the sharing of razor blades were cited as factors.

Latin American Focus: Major Conferences, Forthcoming Reports

The Alliance will sponsor two major events at the Latin American HIV and AIDS regional meetings in Santiago, Chile, November 15-18. The first is a public session that focus on military AIDS prevention and the Alliance initiatives; the second is an invitational planning seminar for eight nations to plan initiatives on civil-military AIDS prevention for the region.

General Sergio Olmedo, Chilean Air Force, will lead the two sessions, which are made possible by a grant from USAID and AIDSCAP. The overall conference is the X Congreso Latinoamericano de E.T.S./IV Conferencia Panamericana de Sida. (November 15-18, Santiago, Chile)

The Alliance Newsletter for January 1996 will feature several brief reports on the Santiago initiatives.

Australia

Spotlight on Conflicting Military HIV Policy

Michael Alexander

The Australian Defence Force's policy on HIV has been found to be in breach of the country's discrimination laws.

The policy, in force since 1989, requires that all new recruits are tested on entry, and any recruits who test positive for HIV are discharged. Existing defence personnel are tested from time to time in various prescribed circumstances. Serving personnel who test positive are discharged if they have HIV Category 3 or Category 4. If they have HIV Category 2, their employability is assessed by a medical board on a case by case basis.

As of 30 December, 1994, 147,673 tests had been carried out by the defence force. Forty-six had tested positive, including three new entrants and 43 serving personnel. All but 11 had been discharged from service.

A complaint was made to Australia's Human Rights and Equal Opportunity Commission by an army recruit ("X") who was discharged after testing HIV positive.

"X" joined the Army Reserve in 1991 and served as a signaller for two years before applying to enlist in the Regular Army. Prior to enlistment he completed a medical history questionnaire acknowledging that he would be tested for HIV, Hepatitis B and Hepatitis C. As part of the questionnaire he acknowledged that he would be discharged if he was diagnosed with any of these conditions. He was also interviewed and given aptitude tests, medical tests and psychological tests.

He commenced recruit training, and a month later the Army notified him that he was HIV positive. He was discharged two days later.

"X" was referred to a doctor who found him to be free of symptoms and in excellent health. His condition was diagnosed as HIV category 2.

"Inherent requirements of the employment"

The primary defence relied on by the Army was that "X" would be unable to carry out the inherent requirements of the particular employment in the Army because of his disability (HIV).

The Army argued that "deployment" is an inherent requirement of employment in this branch of the Army. Deployment was not available to "X" because of the risk of transmission to other soldiers. It was submitted that a soldier, whether in training or in combat, may suffer an injury which may involve the discharge of bodily fluids, including blood, which may be transmitted to the body of another by some form of physical contact. This might occur in circumstances ranging from an urgent blood donation or major blood spill because of serious injury incurred in combat, to accidental contact with even a small blood deposit, e.g. on an obstacle used for training purposes by another who may have even a small skin lesion.

The Army called evidence from a senior HIV doctor, who also holds the rank of Lieutenant Colonel in the Army Reserve. The doctor described the risk of transmission by exchange of bodily fluid as "not zero", and said there is a "potential" for transmission to occur. He acknowledged the likelihood of there being HIV positive personnel in the Army whose identity is not known. He said that proper education and universal precautions are of major importance in minimizing the risk of transmission. He also acknowledged the fact that the use of protective devices such as rubber gloves might not in fact be used by soldiers in the field when going to the aid of a wounded or injured comrade, nor might the soldier take appropriate care to ensure that such protective equipment was maintained in good order and condition.

The Commission accepted the doctor's evidence that "in some extreme circumstances transmission of bodily fluid might readily occur in the course of Army service, but that in others the risk was 'very low' but 'not a fanciful risk'".

However the Commission found there must be a clear relationship between the so-called inherent requirement and any alleged incapacity or inability derived from the disability. In this case, there was no such relationship, as "X" was a competent signaller and in good health.

The Commission found rather than being a personal consequence of the disability, the constraint on deployment was because of an externally imposed requirement of the employer, based on policy considerations, which were designed to reduce the risk of HIV infection.

The Commission distinguished between the "inherent requirements" of employment and the "incidents" of employment:

> it is an inherent requirement of employment as a carpenter that he or she must be able to do the work which is essential to the performance of that trade; it is an incident of the employment that the carpenter may be transferred by the employer from one location to another in order to exercise his or her carpentry skills. ... In my view the 'inherent requirements' of employment as a soldier ... is that the soldier be able to execute the tasks or skills for which he/she is specifically prepared as a soldier irrespective of where the soldier is located or deployed. It is an incident of employment that the soldier may or may not be deployed to a specific location.

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The Military Age Group

HIV/AIDS and Peer Educators in Mexico

Susan Pick and Dean Hall

Adolescents as a population are extremely vulnerable to HIV transmission, due to the fact that they are just beginning to explore their sexuality. To further demonstrate this point, it is important to note that in Mexico, AIDS is the fifth leading cause of death for men between the ages of 24-34, indicating that many were infected most probably between the ages of 15-24 (Secretary of Public Health, 1995). Additionally, a study carried out by the Population Reference Bureau found that 55 percent of the female adolescents interviewed had had premarital sex. A representative home study conducted in Mexico City with female adolescents showed that 77 percent of the girls ages 18-19 were sexually active (Pick de Weiss, et. al. 1988). The same study found that only 38.1 percent of adolescents used some type of contraceptive method during their first intercourse. Another study in 1988 showed that while 73 percent of university students surveyed said that AIDS was the most serious sexually transmitted disease, only 9.1 percent of those that were sexually active always used a condom (Secretary of Public Health, 1989).

Societal values and family structure have affected how people experience relationships and sexual activity over the past decades. Conservative norms have permeated the majority of Latin America, creating the impression that activities and attitudes related to sexuality coincide with the norms. However, Mexican national opinion polls have shown that the majority of the population maintains liberal views in regard to sexuality and sex and family life education (Pick, 1994). This information has helped foster societal support for sex education and other programs and policies related to sexuality.

Effective sex education, including specific information on safe sex behavior, is necessary to prevent HIV/AIDS from spreading into the adolescent population. With this in mind the Mexican Institute for Family and Population Research (IMIFAP) designed an educational program to train adolescent peer educators to deliver the message of HIV prevention in their schools.

Seventy-seven peer educators were trained in the IMIFAP sex and family life education program *Planeando)* tu *Vida* (Planning your Life), which contains topics such as pregnancy, contraceptives, the biology of human reproduction, values, self-esteem and verbal and non-verbal communication. In addition the peer educators were trained specifically in HIV/AIDS prevention strategies. Each of the peer educators have and continue to implement the programs in their schools. Evaluations carried out by IMIFAP staff have shown that the programs presented by the peer educators have had a statistically significant influence on the student's attitudes surrounding issues of sexuality, as well as an increase in knowledge of HIV disease, its transmission and prevention. The success of this program has enabled us to implement it in other parts of Mexico.

Contact: Dr. Susan Pick and Dean Hall, Instituto Mexicano de Investigacion De Familia y Poblacion Apartado Postal 41-595 Mexico, D.F. 11001. Fax 563 62 39 ❑

Australia

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Responses to the decision

The Defence Minister, Senator Robert Ray, reacted with hostility to the Commission's decision. On the day the decision was released, he said that an appeal would be lodged. "I totally disagree with the decision and if I get the support of my colleagues I'll legislate (to enshrine the blanket ban against HIV positive soldiers)", said the Minister. He went on to say it was proper for the defence force to maintain the highest health standards. He said overweight, underheight, Hepatitis B and C positive people and a range of others were banned from the defence force, and so should HIV positive people.

Chief defence spokesman Brigadier Adrian D'Hage said "this is a very strong issue for the defence force... The defense force is the insurance policy for the country, and unlike the police or the ambulance service or the fire brigade, we are unable to call up an ambulance with people who will deal with spilled blood with gloves and other necessary equipment. It is not possible for anyone in the defence force in the front line to worry about rubber gloves", he said. "We've got to be confident we're HIV free. OK, it's only as good as the last test, but it's still a good morale boost."

The President of the Australian Federation of AIDS Organizations, Bill O'Loughlin, welcomed the Commission's decision. "This is an important victory for people with HIV and for all people with disabilities," he said. "The Defence Force, like other employers, has to comply with the law. People with HIV are quite capable of serving their country, and should not be prevented from doing so." Mr O'Loughlin said it was offensive to talk about the presence of people with HIV in the workplace as bad for morale.

Bill O'Loughlin pointed out this was the first HIV case to go all the way to a full hearing under the *Disability Discrimination Act.* "It sends a bad message to people with HIV for the government to immediately talk about changing the law, after the first hearing. All other employers have to comply with it, and government should now accept that military employment is also covered. We are happy to work with the government in drawing up a new and workable HIV policy for the defence force." ❑

Training Program

Resource Guide

THE U.S. ARMY PROGRAM:

Development Continues

The U. S. Army Program has addressed issues of HIV for a decade and continues to search for more effective prevention strategies.

Screening. In 1985-86, the Army began a massive annual program of routinely screening one million active and reserve soldiers and civilian applicants for military service. During 1985-94, 3,864 active and reserve soldiers were diagnosed with HIV-1 infection, plus 416 family members. Incidence rates of newly infected soldiers have declined from year to year, from 2.83 to 0.19 per 1,000 between 1985-86 and 1994. The rate among male applicants for military service declined from 1.77 to 0.35. In 1994, prevalence among female applicants (0.53) exceeded that of males for the first time. The incidence rate for minorities, notably male and female blacks, is consistently higher than that of whites. In 1994 the total of new cases among all active and reserve soldiers was 150, and the total of HIV-positive active duty soldiers was 362. At a time that HIV/AIDS has been spreading in the general population, these low and declining numbers suggest the Army has implemented a successful prevention program.

Prevention program, Army-wide workshops began in February, 1986 to familiarize medical personnel with the new HIV/AIDS disease and the Army's mandatory screening policy. Following this, guidelines were published for evaluation, counseling and management of infected individuals and their contacts. In 1988 the Army mandated HIV/AIDS education annually for all troops. All unit commanders must include HIV/AIDS in their information programs. Every Army installation must have a comprehensive education plan for the military, family members and civilian personnel. There have been five Army-wide biennial HIV/AIDS conferences. Army Public Affairs has Implemented an Army-wide HIV/AIDS Information Plan utilizing print and radio to convey the message that prevention has high priority.

Since 1986, HIV Nurse Educators have been hired to provide HIV/AIDS education programs for the Army installations. They are responsible for providing education and training for military personnel as well as their families and Department of Defense civilians. Some are also responsible for counseling and program management. Preventive medicine physicians and Army Community Health Nurses also provide education and counseling.

For the HIV Nurse Educators there have been numerous train-the-trainer programs. The earliest were in collaboration with the California Nurses Association. They have continued with the American Red Cross. The Army has implemented course programs for other health care workers and for counselors additionally. A certification course for military and civilian Community Health Nurse HIV Educators began in 1994.

Also in 1994, the Army began to pursue the idea that Drill Sergeants, who are the authority figures closest to the troops, could be effective as HIV-prevention trainers. A train-the-trainers demonstration project was impressively successful. The HIV/AIDS Instructor Training program will be implemented at the three active duty Drill Sergeant schools. The impact will extend to more than 1,700 Drill Sergeants and 100,000 soldiers annually.

In 1986, a working group reviewed commercially available materials for possible Army use. The Army bought some and produced others, including six videos. It distributed 930,000 copies of one of its four pamphlets. In 1990, it began to implement the Interactive Video program developed for all the American military services. The Army HIV Nurse Educators continued to encourage use of materials produced by the American Red Cross, the Centers for Disease Con-

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EVALUATION OF MILITARY HIV/AIDS PREVENTION PROGRAMS

Systematic evaluation is an important element of any program plan. It enables us to learn whether objectives are being achieved, whether corrective steps need to be taken, and which approaches are most effective. Evaluation leads to the identification of program development obstacles, lessons learned, and best practices.

There are several kinds of evaluation, including review of the process of program implementation and assessment of cost effectiveness. Experts advise that it is useful to do formative evaluations during the stages of program development so that early mistakes are identified before they have long-term or major impact.

One can assess the learning outcomes — in terms of both actual knowledge and the skills soldiers have after completing training. By testing the level of knowledge at the beginning as well as at the end of the training, one may even reach conclusions about the knowledge added.

Most difficult is the assessment of whether training intended to change behavior really changes behavior. That is the most important question, the ultimate test of program effectiveness. It is possible for a soldier to learn much factually, yet, depending on his values, habits and motivation, still not behave differently. Survey research provides one way to find out, namely by asking soldiers whether, after completing the training, they practiced safer sex. When HIV infection is increasing in the general population, it may be possible to infer that one's program is successful if there is no increase in infection among the military. However, a steady or declining rate of infection may also be explained by changes in recruitment or resignations from military service.

There is general knowledge about what needs to be included in an effective behavior change training program. Non-military studies show that providing risk-reducing information alone is not likely to change behavior; intervention strategies must additionally address motivation and behavioral skills.

Evaluations of military programs have produced information and conclusions that are significant for developing programs and preventing HIV/AIDS. We know that:

- the single greatest obstacle to program development is the availability of time
- training produces significant increases in knowledge, and trainees retain the knowledge at a high level for periods of three to six months
- effective training includes decision-making, negotiation and condom skills, and conveying understanding that forming "buddy" relationships among soldiers to keep one another out of trouble in bars and elsewhere is an effective practice
- because it is far more difficult to change behavior than it is to increase knowledge, there is need for reinforcement of initial training

The U.S. Army Program

Continued from page 5

trol and others. In 1994, an Army HIV Educator's Handbook was produced which has attracted widespread interest.

Strategy is being refined as a result of the Army's knowledge-attitudes-behavior practices (KABP) survey. In 1993 the Armed Forces Epidemiological Board concluded that much risk behavior "is not related to knowledge about AIDS, but is embedded in personality factors and behavioral patterns that are quite resistant to change from current educational efforts. Rather, intensive counseling, either individual or group, behavioral training programs and changes in peer culture are most likely to effect change in behavior. Focused and intensive programs for persons at high risk are to be preferred to programs for all personnel. The second important new direction would be to focus on personnel who are at risk for HIV seroconversion associated with demographic and geographic factors rather than their own levels of risk behavior. ... Again, focused prevention programs for those who are at high risk because their sexual partners are likely to be HIV infected are preferable to programs for all personnel. These recommendations lead to new challenges in program development.

The budget for Army HIV education within the continental United States is $4 million per year, which is approximately 15 percent of a roughly $28 million HIV program budget that includes the costs of screening and treatment. In overseas commands, education accounts for 40 percent of the HIV program budget. There are no treatment costs overseas, as soldiers who become infected are reassigned to the United States for staging and treatment.

Contact; Colonel Adeline G. Washington, U.S. Army Center for Health Promotion and Preventive Medicine, Aberdeen Proving Ground, MD 21010-5422. Tel: (410) 671-2303; Fax: (410) 612-8513

Note: *The Civil-Military Alliance Newsletter*, Issue 3 Supplement contains articles on the U.S. Air Force and U.S. Navy training models and on the interactive videodisc program developed for the U.S. military. ❑

—Compiled by Sven Groennings

Alliance Business

Importance of Civil-Military Cooperation Underscored in Worldwide Communication

Editors Note: In a message sent to 150 nations, the importance of the cooperation between civil and military communities was emphasized as crucial in the struggle against HIV and AIDS. The message sent by one of the Alliance sponsors, the United States Agency for International Development (USAID), to US embassies suggested the Alliance can be helpful in HIV and AIDS prevention activities. The message is reproduced in part below.

• The Alliance was formed on two premises. Because the HIV/AIDS problem for militaries stems largely from interaction between civilians and military personnel, and the impact affects both populations, civil-military collaboration is essential. In some regions other world, military/security forces have become one of the most important high-risk core groups for HIV transmission (both intra- and internationally within the civilian population. Given the permeability of national borders solutions, international cooperation is essential. Any country sending military forces to other countries becomes a stakeholder in effective civil-military collaboration.

• Globally, the military tends to have sexually transmitted disease rates that are 2 to 3 times higher than that of civilian age group counterparts. These rates multiply in wartime or during civil conflict. Military populations are highly vulnerable because they combine and occupational preoccupation with high risk-taking and a sense of invincibility; by and large, soldiers have disposable income, are mobile, and lack the usual behavioral constraints of a home community.

• The military's contribution to the spread of HIV/AIDS has important implications not only for military preparedness, military morale, recruitment rates, and blood supplies, but also for national AIDS control programs, hospital facilities, widows, orphans, child soldiers, human rights, economic development, and especially political stability. Policy issues include host country conditions for stationing allied troops, testing, care, preparations for demobilization, and education programs.

• Peacekeeping forces, now active in 16 countries, are more likely to contract HIV than to be killed in action. Often they are far more vulnerable than forces stationed in their home countries because of deployment in areas of higher endemicity, and then take infection home with them, further spreading the disease.

• As the HIV/AIDS epidemic saps the economic strength of affected countries, high rates of HIV infection among the police and military personnel threatens internal security and regional stability. Although the demobilization of military/security forces may lead to smaller, more economical force structures, it may also significantly spread the distribution of the epidemic through HIV infected soldiers returning to their rural homes. This underscores the critical need for military/security forces to join forces with their civilian counterparts to "declare war on the HIV/AIDS epidemic."

• Given the above, the military may not only contribute to the HIV/AIDS problem — it may contribute significantly to the solution. Examples might include the training of demobilizing soldiers (both those HIV-infected and those free of infection) to become peer-educators when they return to their civilian communities, and the use of national military logistic systems (often, the only functions supply system in many countries) to distribute HIV/AIDS educational materials, STD drugs, and condoms country-wide for both civilian and military use.

Seizing the Opportunity:

HIV Prevention in Military Communities

Lt. Col. Craig W. Hendrix

Aggressive HIV prevention methods dominated discussions at the Southern and Southeast Asia Regional HIV/AIDS Training Seminar in Cha-am, Thailand. Practice diverges where some nations respond to the possibility of an epidemic threat, whereas others respond to the reality of an epidemic. The magnitude of response varies with the perceived severity of the threat and the availability of resources. Historically, the U.S., Europe, and Africa could only respond to AIDS cases due to the unavailability of an HIV test, rather than respond to the underlying HIV epidemic that occurred years earlier. The accelerated nature of the growing Asian HIV epidemic now demands consideration of more vigorous, early responses using available technologies.

Accelerated Asian Epidemic

Participants at the Cha-am seminar heard several lines of converging scientific evidence that may explain the more rapid pace of the Asian epidemic. The epidemic in Northern Thailand, in comparison to the West, is largely heterosexual, associated with greater transmission risk per sexual exposure, and the virus is predominantly of the "E" clade or genetic family. In the US and Europe, it is largely men that have sex with men or injection drug users who are HIV infected, predominantly with the "B" clade virus. New evidence suggests that E clade viruses more easily infect cells in tissues exposed to HIV in heterosexual sex, unlike the B clade viruses that much less efficiently infects these cells. Finally, researchers recently identified E clade viruses in US servicemen. This information suggests that the more aggressive epidemic in parts of Asia is due, in part, to characteristics of the predominant virus in the region. Further, this virus can seed populations outside the region. Accordingly, less time may be available for implementation of preventive interventions based on HIV surveillance.

Knowledge of the behavioral risk of a population may define the vulnerability of a population to HIV even before HIV surveillance methods detect infections. Before a regional HIV epidemic occurs, effective HIV prevention programs could be employed to "behaviorally immunize" a population. HIV surveillance of sentinel populations (commercial sex workers, injection drug users, sexually transmitted disease patients) then provides an early warning signal to augment prevention interventions. Nations largely unaffected by HIV, including some of those present in the Cha-am discussions, may remain so by a measured pro-active response of this nature.

Misplaced perception of risk

Some seminar delegates perceived minimal military HIV risk unless deployed overseas, as in peacekeeping operations, although their civilian populations have already recorded growing HIV epidemics. They believe adherence to religious or professional military standards precludes HIV risk behaviors when at home in their country of origin. Accordingly, some militaries implement HIV surveillance only upon return from overseas deployment. These prevention programs may too narrowly target only the deployment risk. Absence of non-deployment surveillance may fail to detect HIV transmissions at home and may dangerously delay effective interventions.

Despite the perception of limited susceptibility to HIV, the delegations at Cha-am presented plans, either in place or to be considered, to combat the HIV epidemic within their military. Usually, delegations highlighted the need for increased emphasis on civil-military cooperation. Approaches included general military preventive education, institutional changes to minimize risky behaviors, and condom availability, if not active condom promotion and distribution.

The Thai Case

Where the operational priority and fiscal opportunity for HIV prevention activities exists, military organizations may be among the most successful at reversing the HIV epidemic. Thailand responded vigorously and effectively to the regional HIV epidemic, largely due to newer technology that made HIV serologic surveillance possible. In response to HIV surveillance reports, the Royal Thai Army implemented control programs and significant declines in army HIV incidence rates followed. In the recent study of a behavioral intervention among Royal Thai Army soldiers, investigators measured dramatic reductions in HIV incidence. Military HIV surveillance programs can provide the data to measure the effectiveness of prevention interventions. Surveillance also allows earlier medical interventions to prevent HIV disease progression. Success with either of these efforts will contribute to the maintenance of a military's readiness despite the HIV epidemic.

Summary Points

- Early and aggressive interventions prevent epidemics from taking root
- Rapidly spreading HIV strains in Asia are infecting soldiers in distant populations
- HIV risk occurs both before and after military deployment
- HIV surveillance provides an essential tool to measure the severity of the epidemic and the efficacy of preventive interventions
- Behavioral intervention in military populations can dramatically reduce HIV incidence ❑

Report: First Regional Seminar for South and Southeast Asia on AIDS PREVENTION IN MILITARY POPULATIONS

Organized by the Economic Development Institute of the World Bank in consultation with the World Health Organization/Global Programme on AIDS, the Joint UN Programme on HIV/AIDS,

Participating Countries:
Bangladesh, India, Indonesia, Malaysia, Nepal, Thailand

Observations by the participants

• This was the first occasion that the leadership of the medical services of the armed forces, and the leaders of the national (civil) AIDS programs of the six participating countries had met together on a topic of common concern and interest.

• The participants felt the HIV/AIDS epidemic posed a challenge to all of them even for those countries presently reporting a low HIV prevalence. They felt this encounter offered them an exposure to and examination of policy issues in a new lights as perceived and expressed in their neighboring countries. It was a chance to exchange and learn from policy views; and program approaches that would benefit their own policy reflection in the future.

• They further realized that, although they had begun with widely varying experience and policy approaches, they had quickly come to a consensus on many issues, and this would lead them to review their policies and practices on their return home. They affirmed they had learned much from each other and that this kind of shared policy reflection should become a continuing element in their own national civil and military health program development.

Issues and Challenges

• Understanding and addressing the risk factors. Further study is needed to better understand and to deal with the vulnerability of armed forces personnel and their families to this epidemic and to other sexually transmitted diseases. Policy review may be needed in relation to:

(a) duration of postings away from home and family including deployment on UN peace-keeping missions,
(b) availability of accommodation at military bases to make marriage a more feasible option for all personnel,
(c) aim to raise the level of education in serving military,
(d) recognizing the role and importance of religious principles and social mores in determining behavior and making use of these societal forces, and
(e) addressing issues related to alcohol use and intravenous drug injecting habits that increase the risk of HIV transmission.

• Strengthening the implementation of identified prevention priorities. Approaches that may need to be strengthened include:

(a) health education anal briefing of all troops, their families, health care staff and commanders — to include on-induction briefing, periodic review and rebriefing, pre- and post-deployment briefing, briefing while on deployment, and pre-discharge (demobilization) briefing;
(b) promoting fidelity in marriage but also teaching and promoting the consistent use of condoms for those not living in faithful, one partner relationships;
(c) making adequate and accessible supplies of high-quality condoms available to all troops
(d) ensuring the application of universal precautions in all health care settings; and
(e) ensuring the safety of blood supplies and blood products, while teaching the rational use of those products.

• HIV Testing: The policies, practices and experience of these six countries in entry testing was discussed at length. It was considered desirable to introduce HIV-testing prior to cadet entry into officer and other advanced technical training (such as pilot training). Testing will be done prior to sending personnel for training or for deployment in other countries in cases in which the host country lays down such a requirement. Testing prior to taking part in UN peace-keeping missions will follow UN recommendations. Most countries are already screening troops on their return from such deployment. Other reasons for testing, such as with STD patients, for diagnosis of illness thought possibly to be HIV-related, and for surveillance, are already being followed.

• The practice of pre-induction testing of recruits is followed by some countries. For others, this is not a requirement, particularly for those states with extremely low prevalence levels at this time.)

Civil-Military Collaboration

• The importance of civil-military cooperation and collaboration in all realms related to STD and HIV/AIDS was generally recognized. This could extend to consistent, mutual participation in the relevant National and Military AIDS Committees, sharing training and other technical facilities, cooperation in research efforts and field trials, etc. Where this is not the regular practice, participants expressed the intention to explore these possibilities at home.

Follow-up

• The potential was identified for much dynamic cooperation on a military-to-military basis between countries in relation to HIV/AIDS control. This should begin with increasing contacts between the militaries, exchange of information, documents and training materials, and offering training opportunities. Linkages between countries would also be considered through internal newsletters, active participation in the (Civil-Military Alliance to Combat HIV and AIDS, and taking the opportunity to meet during joint participation in other meetings. The formation of a regional body to support inter-country cooperation was suggested, and will be studied.

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INTERNATIONAL CONFERENCE ON AIDS FOR ASIA AND PACIFIC

CHIANG MAI, THAILAND

18 September 1995

Satellite Symposium Sponsered By The Civil-military Alliance

"AIDS PREVENTION IN MILITARY POPULATIONS"

FIRST PANEL

Chair: **Ms. Teresita Bagasao**, Executive Director, Partnership with Filipino Families; and Secretariat, Asia-Pacific Council of AIDS Service Organizations (APCASO), Philippines

Panelists:

• **Dr. Stuart Kingma** (UNAIDS):
AIDS in the Military — the overall situation, and an introduction to the Civil-Military Alliance to Combat HIV and AIDS

• **Mr. Alan Greig** (UNDP):
Civil-military interaction, regional security implications

• **Dr. Flavio Del Ponte** (DPKO):
UN Peacekeeping Operations

SECOND PANEL

Chair: **Maj. General Preecha Singharaj**, Assistant Surgeon General, Royal Thai Army Medical Services

Co-chair: **Col. Damanhuri Rosadi**, Head, Subdirectorate Office of the Director of Health Services, Department of Defense and Security, Indonesia

Country case studies

• Thailand: presented by **Col Suebpong Sangkharomya**, Royal Thai Army Medical Department

• Indonesia: presented by **Dr. Hartono Purwo**, Directorate of Health, Dept. of Defense and Security.

• Cambodia: presented by **Dr. Tan Sokhey**, Health Department, Ministry of National Defence, Cambodia

CALENDAR 1995-1996

NOVEMBER 15-18
SANTIAGO, CHILE

Tenth Latin American Congress on Sexually Transmitted Diseases
IV Pan American Conference on AIDS,
Contact: Dr. Bianca Ocampos, Organizacion XM, Andresde Fuenzalida 22, Of. 303, Casilla 200, Providencia, Chile Tel: 231 9362, Fax 232 2559.

NOVEMBER 26-DECEMBER 1
JERUSALEM, ISRAEL

9th International Conference on AIDS Education
Contact: Conference Secretariat, PO Box 50006, Jerusalem, Israel Tel Aviv 61500, Israel. Tel (972 3) 514 0014, Fax: (972 3) 660 325/517 5674

DECEMBER 1-4
BEIJING, CHINA

'95 China International Symposium on AIDS: Integration of Traditional and Western Medicine in Preventing and Treating HIV/AIDS
Contact: Mr. Pan Ping, '95 CISA, Science and Technology Cooperative Ctr. China Academy of TCM, No. 18 Beixincang, Dongzhimennei, Beijing 100700, China, Tel/Fax +86 10 407 5193, Fax: +86 10 406 1635

DECEMBER 10-14
KAMPALA, UGANDA

9th International Conference on AIDS and STDs in Africa
Contact: AIDS Conference Secretariat, PO Box 6, Entebbe, Uganda. Tel: (256 42) 20297, Fax (256 42) 20608,

MARCH 18-21 1996
BANGKOK, THAILAND

International Congress on Drug Therapy in HIV Infection
Contact: Jane Fensome, Conference Coordinator, Tel: +44 1625615325, Fax: +44 1625 616563

JULY 7-12 1996
VANCOUVER, CANADA

XI International AIDS Conference on AIDS
Contact: Secretariat, PO Box 48740, 595 Burrard Street, Vancouver, British Columbia, Canada V7X IT8, Tel: +1 604 631 5576, Fax: +1 604 631 5210, email: <aids96@hivnet.ubc.ca>.

AUTHORS' BIOGRAPHIES

Michael Alexander, LLB MA, is Legal Policy Analyst at the Australian Federation of AIDS Organizations based in Sydney, and is the editor of *HIV/AIDS Legal Link.*

Sven Groennings, Ph.D is the Washington, D.C. representative of the Civil Military Alliance. He has been a professor of Political Science, a member of the US State Department, a staff officer for a U.S. Senator, and author or editor of five books.

Stuart Kingma, M.D., is an American surgeon with 34 years experience in international health, beginning with nine years in a rural hospital in Nigeria. Since 1984, he has been on the staff of the World Health Organization.

Craig W. Hendrix, M,D., is a Senior Scientist at the Division of Retrovirology, Walter Reed Army Institute of Research, USA.

Norman Miller, Ph.D, the editor of the *Alliance Newsletter* and *AIDS & Society,* is author of *AIDS in Africa: The Social and Policy Impact.* He also serves as a professor at Dartmouth Medical School, USA.

Dr. Susan Pick Ph.D and Dean Hall Instituto Mexicano de Investigacion De Familia y Poblacion Apartado Postal 41-595 Mexico, D.F. 11001 Fax 563 62 39

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The editors of the *Alliance Newsletter* are seeking brief articles, news items, research reports, book notes and up-coming conference notes, to be published in our next issue.

TOPICS OF INTEREST

- Prostitution and the Military
- Research Findings on Civil-Military Aids Issues
- Issues of Families, Military Children, Child Soldiers
- Issues of Sex Workers in military communities
- Issues of Peacekeeping and AIDS
- Issues of demobilization, AIDS prevention
- Bibliographies and Resource guides

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Civil-Military Alliance to Combat HIV and AIDS

Alliance NEWSLETTER

Volume 1, Number 2 April 1995

Inside:

IN THE NEXT ISSUE:

July, 1995
Special Focus

Training materials, resources training aids, and manuals

North-South Differences

Policy Ambivalence On Military AIDS Prevention

Norman Miller

A north-south difference in military AIDS prevention has surfaced in recent months, particularly in the United States where budget reductions have highlighted problems in deciding what priority should be assigned AIDS issues. In the "south" particularly in Africa and Asia militaries are being decimated by HIV and AIDS. In some African countries up to 50% of their nations army is infected. Trained personnel are being lost and the nations capacity to protect itself and maintain civil order is coming into question.

For northern nations such as those in Europe and North America, the issue depends on what sector of government is assessing the problem. Strictly from a military point of view, it has been argued that AIDS is not an immediate "war stopper". It will not prevent a soldier going into battle as say malaria or denge fever. HIV and AIDS in most western militaries exists, but not in such numbers as to be alarming to military leaders. (Many western militaries do not test recruits or regular soldiers, so in fact the reality may not be known.) The United States, for example has had some 6,000 infected troops on active duty, (currently 1,200), another 4,000 in the national guard and reserves, and some 18,000 receiving treatment at Veterans hospitals.

Other departments or ministries of government, on the other hand are often extremely concerned. From the broader perspective of a foreign affairs ministry, AIDS is a "war starter" that can lead to internal upheavals and strife, international instability and conflicts that can destroy governments. AIDS is a major dilemma for peacekeeping. Rwanda gives us a sobering example of how AIDS can be used as an implement of war. (see box, page 3)

Thus the argument is joined within branches of western governments. Many military analysts do not see AIDS as a direct threat to their own troops; foreign policy analysts see AIDS in third world militaries as an enormous threat, not only to the well-being of a given nation, but to the peacekeeping troops that may have to go in to keep the peace or quell upheavals. The argument here is that peacekeepers would not have had to be deployed in the first place, and thus be in jeopardy, if AIDS- caused or AIDS-related disruption had not occurred.

In short, western governments are conflicted on the international military AIDS issues. One view saying "do not worry"; another view saying "yes, worry" because the issue is a major problem of destabilization. The first

Continued on page 3

Letter to the Editor

Alliance: More Issues to Consider

The aims of the new "Civil-Military Alliance to Combat HIV and AIDS" are laudable. This area has by and large been ignored over the past decade. However, the aims do not go far enough. Let us examine two realities.

First, there has been an increase in the number of conflicts over the past decade. The majority are internal, civil wars between government and rebel forces; ethnic conflicts; and clashes over resources. We have to accept that these low-intensity conflicts will continue and look at the effect they have on HIV transmission. The second reality is that in many countries a sizable portion of the population is already infected with HIV. In all probability the level of infection is higher in the uniformed forces.

The first reality means that we need to establish a research agenda to look at how conflict increases HIV spread and if there are points for intervention. It seems that conflict will result in an increase in rape and multiple sexual partnerships; at the same time public education campaigns will falter and cease. We need to know more about these intervention mechanisms, how and why they occur and what we can do. It may be that where "blue-helmet forces" are used there should be an STD control emphasis for servicemen and women and the general population. Perhaps relief operations should include AIDS education; condoms; and STD treatments.

The second reality has serious implications for the operations of the military and other uniformed forces. Will an increase in mortality affect the chain of command and the stability of the service? Will morale drop? Clearly the effect of high levels of HIV will affect both the ability to operate and the way in which forces operate. Again this is a plea for further research. We need to know what effect the disease will have and what we can do about it.

The Alliance has much to do. In the past, attempts to counter the spread of HIV have been described as a battle or fight. The use of military metaphors has been criticized, but they are apt. Hopefully the Alliance will point the way for less regimented groups in society. It is vital they recognize that it is not a "what if HIV spreads" scenario we are dealing with. In many countries it is a "because AIDS is here" scenario and in others it will be a "when it spreads" scenario. We have to look at the downstream effects as well.

Alan Whiteside
University of Natal
Durban, South Africa

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4 West Wheelock Street
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Policy Ambivalence On Military AIDS Prevention

Continued from page 1

position argues that, it is not a western nations right to focus on the internal affairs of another nations military. On the other hand, to stop the epidemic from undermining allied militaries, a multi-sectoral, coordinated response is needed. The issue is juxtaposed between specific self interest and broad foreign policy interests.

Since there is no major disagreement on the facts—non-western militaries are in very difficult straits. Why is there such ambivalence in the west? Reasons include:

• *Cold War Traditions:* Western militaries have been poised to fight one kind of war; changing to face new threats takes time. Low intensity conflicts, peacekeeping missions or other interventions call for new tactics, new weapons, new training, new language skills, and new analysis of background political factors.

• *Fragmentation of Responsibility:* Getting at the causes behind military upheaval or a Rwanda-style situation has not been the main responsibility of militaries. To take on new responsibilities, such as military HIV and AIDS prevention, or even the analysis of what the impact of AIDS might be in a given situation, is not seen as the responsibility of a defense ministry. AIDS issues, like environmental issues or population explosion issues, are seen as too broad and too remote to be of immediate military relevance.

• *Unclear Mission:* Since militaries must be prepared to defend their nation, and to back-stop civil authorities within the nation, it can be viewed as irresponsible to take on broader issues like AIDS prevention. In times of program cut-backs, the tendency would be to protect existing programs, not initiate new ones.

WHAT CAN BE DONE? WHAT IS NEEDED?

The problem of military AIDS prevention in most nations falls between bureaucracies and in the cracks of government health, defense, foreign affairs and finance. No matter how direct a security threat the AIDS issues may be, in most governments no one department of ministry is in charge.

In one respect, the dilemma for the west is ironic. Military establishments have some of the world's best expertise on the prevention of Sexually Transmitted Disease (STD). They have superb training capabilities, detailed training materials, and many specialists in preventative medicine and behavioral change. Western militaries have civil-affairs experts that evaluate related issues. For example problems confronting troops on long term deployment, or concerning off-base prostitution, alcohol abuse, or visits to foreign ports are all problems under constant scrutiny.

The key response for western militaries lies, first, in recognizing their own self interest in assisting developing world allies with the problem. Second, given budget constraints, the problem should be defined as one that can be handled in many departments, with existing resources, calling on in-kind support rather than new funds. Third, there is a need in many western nations for a senior, inter-agency or inter-ministry policy group, one that gathers information, stays abreast of the global problem and works toward programs with and for the military.

Low-cost programs can also be launched that tie into existing initiatives. For example, in the U.S. there are a number of programs that could carry AIDS prevention training such as: Medical Civic Action Programs (MEDCAPS), Medical Readiness Training Exercises (MEDRETES), Mobile Training Teams (MTTs) and others, are all potentially useful in fighting the spread of HIV / AIDS.

The policy dilemma in military AIDS prevention will not diminish until it is confronted directly. If western states do not face the crisis now, the costs of doing so later will be higher and the complexities greater. ❑

Military Issues and HIV/AIDS in Africa

Some 70% of the worldwide total of HIV infected adults—approximately eight million—are in Africa.

For most African states, military and security forces are a high-risk group that exacerbates the transmission of HIV in civilian populations. Some of the anticipated impacts:

• an increase in deaths among young Africans of the magnitude predicted is likely to have a substantial negative effect on economic, political and military stability.

• AIDS undermines political and civil order by striking at the leadership and "hollowing out" the core of trained personnel in many economic sectors.

• illness and death of officers and non-commissioned officers seriously disrupts military units and can cause untimely competition for rapid promotion in the ranks.

• the demobilization of African military and security forces can be expected to exacerbate the epidemic through military personnel who return to their home areas with high rates of infection.

HIV As A Weapon of War

RWANDA—Evidence is emerging that HIV has been used as a weapon of war in the ethnic conflict here. Prior to the outbreak of violence, Hutus charged that they feared that the Tutsi would inject them with HIV virus. Rape and concubinage were common during the conflict, with pre-war estimates of HIV infection among soldiers at 45-60%, and even higher in the officer corps. According to Dr. Joseph Kaeemera, the new minister of health, when women were captured, they were deliberately taken to HIV positive soldiers to be raped. Even though the fighting has stopped, nearly two million Rwandans are in refugee camps, where rape and forced marriages continue. [WorldAIDS, 3/95].

Combating HIV and AIDS

Key Policy Issues Face the Civil-Military Alliance

Rodger Yeager

On November 20 and 21, 1994, the Civil-Military Alliance held its first planning conference in Rockville Maryland, at the Henry M. Jackson Foundation for the Advancement of Military Medicine. The purposes of this conference were to determine the organizational structure and mission of the Alliance, and likewise to consider the major implications of HIV/AIDS for national security and, in particular, for international peacekeeping commitments.

The discussions involved 30 military-medical officers, health and development specialists, and policy analysts drawn from eight countries. Senior officers from the United Nations Development Programme, the World Health Organization, the Pan American Health Organization and the U.S. Dept. of State also participated. During their meetings, conferees reach agreement on a number of challenges that must be met if successful prevention and education programs are to be mounted against the disease by civilian and military organizations working in cooperation with each other.

NATIONAL SECURITY ISSUES

HIV/AIDS will not subside and, without action, will only grow in strength well into the next century. There is also a direct link between HIV/AIDS prevention and the achievement of democratic stabilization, sustainable development, and global security.

HIV/AIDS is not only a public health problem; it is also a major political, economic, and security threat. In the United States and other industrialized countries, the pandemic poses no immediate threat to military readiness. On a wider scale, the disease has not proven to be a war–stopper but it can cause catastrophic consequences in terms of fear of infection, contaminated blood supplies, decimation of troop strengths, loss of civil and military leadership, socio-economic and cultural disruption, and military–political instability. In this sense, the virus menaces all countries, and especially in light of the evolution of new and more virulent strains, the slow and halting development of vaccines, and the rapid spread of infections in Africa, Asia, and other sensitive world regions. The disease also poses a major human rights problem in that it attacks some of the most vulnerable parts of society. A Civil-Military Alliance to Combat HIV and AIDS is thus justified because of the strategic importance of the pandemic to world peace, and because of the mutual dependence of military and civilian prevention programs. A major unresolved question concerns the extent to which civilian and military leaders are now prepared to consider HIV/AIDS a national security issue as well as a public health problem. A central task of the Alliance must be to convey the message that successful civil-military collaboration will improve the security of all nations, recognizing that if its military is destabilized, a country cannot achieve and/or maintain social, political, and economic stability.

In the developing world HIV produces a variety of potentially devastating losses; loss of skills and income and thus potential for economic growth and diversification, loss to families including the property rights of the deceased, loss of social cohesion, and loss of political stability as the general public and organized interest groups perceive governmental ineffectiveness in the face of increasing infection rates. Developed countries have not yet experienced threats of these magnitudes at home, but the overall situation must be judged as a universal impediment to global security.

In response to the question of why industrial countries should be concerned with HIV/AIDS in developing countries, in an increasingly interconnected world mutual concern is a matter of mutually enlightened self-interest. The U.S. State Department has already acknowledged this fact by devising a Comprehensive International Strategy on HIV/AIDS, which includes an action plan to raise awareness of the pandemic in high-level bilateral discussions, to educate foreign service officers in briefings on the disease, to make known the impact of HIV/AIDS on U.S. foreign business ventures and investments, and to view military organizations as both parts of the problem and, potentially, parts of the solution.

HIV/AIDS presents a direct challenge to national unity, state sovereignty, and international security. The HIV virus will profoundly affect how countries function as civil orders, and although cooperative civil-military actions on this issue have been few to date, both sectors are beginning to appreciate how fundamental these issues have become to social and economic integration and to political stability throughout the world. The creation of the Civil-Military Alliance to Combat HIV and AIDS provides evidence of this recognition.

PEACEKEEPING ISSUES

Between 1993 and 1995, 36 major armed conflicts have raged in Africa, the Caribbean, Central Asia, Europe, Latin America, and the Middle East. Sixteen of these disturbances have led to multinational peacekeeping operations mounted in attempts to control or end the fighting. The human stakes in such struggles are high. At the end of 1993, 13 had already claimed between 1,000 and 10,000 civilian and military lives, nine had caused between 10,000 and 100,000 deaths, and 14 had each produced over 100,000 fatalities. In the tumultuous post-Cold War era, peacekeeping operations have become a routine and critical factor in civil-military relations and in relations among and between industrialized and developing countries. HIV/AIDS bears serious consequences for peacekeeping missions and other types of troop deployments.

Until now the perils of committing forces to areas of high HIV incidence have not been given serious attention. With decreasing resources at its disposal, for example, the U.S. Department of Defense (DOD) has scarcely addressed these issues, and yet the realities of military readiness and deployability will compel it to become more actively involved as the pandemic and armed conflict both continue to spread. There is indisputable evidence that troop deployments for peacekeeping and other purposes increase HIV transmission to and from host countries. Unsettled areas are fertile breeding grounds for sexually transmitted diseases (STDs) of all types, and it is five to 20 times easier to acquire HIV in the presence of other STDs. In addition, incidences of HIV are usually higher in military than in civilian populations, and under wartime conditions infection rates can multiply by 10 to 100 times. During deployments home-style behavior patterns dramatically increase the risk of infection, and coping with this problem requires close civil- military cooperation.

CONCLUSIONS

It is important to emphasize that the deadly connection between HIV/AIDS and troop deployments for peacekeeping and other purposes is really a two-sided relationship.

First, with every new assignment the dangerous trend is extended of peacekeeping forces moving into areas with actually or potentially high rates of HIV seroprevalence. Rwanda provides a recent example involving both military personnel and civilian relief workers. Before the genocidal conflict of 1994, this country already had an urban seroprevalence rate of 30 to 40 percent and a rural seroprevalence of 3 to 10 percent. Today, urban and rural populations are crowded together into squalid refugee camps in Rwanda and surrounding countries, and new infections must surely be multiplying exponentially. Peacekeepers have withdrawn from the camps because of the risks of remaining, and the presence of HIV/AIDS is clearly associated with these extremely unstable conditions.

Second, the dangers do not end when the fighting ebbs and the troops are withdrawn. For example, when 150,000 Cuban troops were recalled from Africa, it was discovered that HIV/AIDS was their second most prevalent disease. This finding reportedly led to the incarceration of the infected, "a move that provoked fear and discontent among the Cuban people."* As civil war has gradually abated in Angola and Mozambique, moreover, the return home of refugees and demobilized local soldiers has served further to spread HIV within these countries' already-ravaged civilian populations.

HIV/AIDS may not be a war-stopper, but in combination with other destabilizing factors it may very well be a war-starter and a war-perpetuator. The Civil-Military Alliance was organized to help change this grim reality, and millions of lives may hang in the balance as the Alliance takes up its critical agenda of applied research, education, and prevention.

*Eliot A. Cohen, "Dynamics of Military Intervention," in Ariel E. Levite et al. (eds)., Foreign Military Intervention: The Dynamics of Protracted Conflict. (New York: Columbia University Press, 1992), p. 275.

Alliance Activities

What can be done?

Recognizing the close epidemiological relationship between civilian and military populations, the World Health Organization (WHO) and the Economic Development Institute (EDI) of the World Bank have included militaries as one sector in their attack on HIV/AIDS in the workplace. In particular, military personnel will be included among representatives of four clusters of countries slated for HIV/AIDS Regional Training Centers. Designated regions include Eastern and Southern Africa, North and West Africa, South and South-East Asia, and Eastern Europe, including the Russian Federated Republic and Ukraine. Insofar as the military is concerned, the EDI will manage the operational side of training, with an emphasis on peacekeeping issues. The Training Centers will sponsor two-step conferences/training sessions: five-day meetings of military and military-medical staffs of the highest rank, concerning policy issues such as testing, care, and prevention. These meetings will each involve 50 to 60 participants; two-week technical sessions for military and civilian medical officers, focusing on linkages between national civilian and military health services.

Conferences and training sessions will be funded by the WHO and EDI, and the Civil–Military Alliance may be able to provide long-term organizational support.

The Alliance will also become involved in several important areas of civil-military and North-South collaboration by assessing the HIV-related causes of civil and military instability, through other forms of information gathering, analysis, and dissemination, and by helping to develop effective education and prevention programs. In addition to initiating the *Alliance Newsletter*, members have already prepared and refined a questionnaire on HIV/AIDS Prevention, Testing, and Care in Military Medical Practice. Special objects of data collection and information sharing could be units preparing for and engaged in peacekeeping missions. The Alliance can further serve an important catalytic function in assisting the coalitions of civil and military authorities which are presently forming in several countries, by helping to secure financial and other assistance for their work. One such source of assistance may be the U.S. Comprehensive International Strategy on HIV/AIDS, whose agenda is not confined to the health sector but also encompasses a wide range of other public issues such as population dynamics, sustainable socio-economic development, human rights, and, not least, peacekeeping.

Rwanda Report

Belgian Military Medicine AIDS: No Cure, but Care

Lt. Col. Raymond M.A. Wouters, M.D.

Education for behavioral change cannot be stressed too much when military personnel are confronted with HIV/AIDS, and for that reason the Belgian Medical Service has created an AIDS Information Team, whose responsibilities are outlined below.

In general, the military community is always at increased risk of contracting (and spreading) the infection. The Belgian experience in Rwanda, where in Kigali 40 percent of the women of childbearing age are infected, is a good example of the complexity of dealing with the disease.

A questionnaire-based survey of 381 of our military personnel deployed in Kigali from December 1993 through March 1994 showed, that 50 percent of the group were celibate. Responses of the sexually active 50 percent revealed that:

- 86 percent always used a condom. Those who did not were usually older (36 years +/-).
- 44 respondents reported one or more condom ruptures. In 1150 sexual contacts, there were 87 incidents of rupture.
- four persons thought they had contracted a venereal disease.
- 86 percent said they had been given enough information about HIV/AIDS.
- 18 percent thought they had exposed themselves to HIV and 16 percent weren't sure about it. and finally, 37.4 percent had difficulty in obtaining condoms in Kigali.

> "The civil and military circumstances are alike: the real issues are safe blood supply, safe sex, safe caring."

In spite of the astounding achievements in understanding and treatment of this disease, there is no real hope for a cure in the forseeable future; the best that we can hope for is to provide adequate care without the promise of a cure. To reduce infection and respond to the needs of those concerned, interventions made at various levels must be integrated into existing health, education, and social systems.*

The military must be considered a specific target-group for intervention because 1) this community is more at risk than the general population, and the circumstances that lead to infection are different; 2) the military's social network is different from that of the general public; and 3) the cultural characteristics of the military must be considered when developing educational messages and strategies. The AIDS Information Team is geared to the unique position that the military assumes. Parts of its mission includes:

- To prevent new infections, personal initiative must be promoted and supported, using images and symbols typically military.
- To prevent negative effects of the epidemic, infected and sick persons must remain integrated in society, and the health and social security system should support them. To that end, civil and military authorities must have an integrated approach.

Belgium's AIDS Information Team, created in response to a volunteer movement to help infected military personnel and prevent the spread of infection, has French-speaking and Dutch-speaking divisions, working side by side in the Queen Astrid Military Hospital in Brussels. They began their work by holding "information sessions" in the medical service, but now go to training centers all over the country. Using both videotape, slides, printed material, and live discussion with a seropositive person, they present the case for prevention, dispel preconceived notions, and effect behavioral change. The team is building a network of local volunteers with the same approach. Team members also design procedures to prevent infection of wounded individuals, arrange anonymous testing, counsel military personnel, and are active in training activities with civil organizations. It is fast becoming a true civil-military alliance.

The approach of the Belgian Army to HIV/AIDS is analogous to procedures used with other chronic and debilitating diseases. Only when the individual has become an invalid will he be discharged, with an invalid's retirement allowance and entitlement to treatment by Military Medical Services.

The AIDS Information Team provides further counseling and buddy assistance, in order to develop solidarity among military personnel and prevent the isolation that results when infected individuals are shunned by their peers. Military medical authorities should be a model for non-governmental and civil public authorities, so that everyone understands that continued military service by an infected person need put none of his/her colleagues at risk, even in the event of trauma and bleeding. In this respect, the civil and military circumstances are alike: the real issues are safe blood supply, safe sex, safe caring. ❑

*See "HIV prevention in Switzerland—Targets, strategies, interventions: a report of the Federal Office of Public Health—The National AIDS Commission

Reporters Corner

HIV and AIDS: Risk in Southeast Asia

Robert Currie

Two curious twists on the HIV/AIDS realities in Southeast Asia have surfaced in recent weeks. In terms of prevention, for the first time Chinese New Year visitors arriving from Malaysia for traditional festivities were given AIDS warning messages to alert them to the perils in Thai brothels. The warnings replaced the usual hospitality gifts offered the largely male visitors.

In a major sign of collaboration, Mahidol University in Thailand is working with the Armed Forces Institute of Medical Sciences in the field trials underway in search of a HIV preventative vaccine.

Also surfacing recently is a debate on the actual extent of the infection among Thai recruits. Overall, Thailand's position on the pandemic is well documented. Last year in *AIDS*, (April 8, 1994:533-7), David D. Celentano, et al, presented data about seroprevalence in commercial sex workers (CSWs) reaching 65% in eleven brothels serving military personnel in northern Thailand. The *New York Times* (3/11/94) and *Washington Post* (12/2/93) had also outlined the spread of infection, especially among I.V. drug users and prostitutes. *Lancet* (1/22/94) reported that sex with female prostitutes was "the principal mode of transmission" for 1,115 male military conscripts, and in *Genitourinary Medicine* (April 1993: 69 (2)) we learn of the infection of 100,000 I.V. drug users, and that "In one year, the infection rate among prostitutes in Chiang Rai Province reached 37%. HIV/AIDS is expected to reach all population groups by the year 2000. While infection among CSWs has been well documented, infection in the military is less certain. Reports that 70% of new recruits in Northern Thailand were HIV positive stirred discussion on the Internet during March 1995. Kiyoshi Kuromiya (Critical Path AIDS Project) reported that at the 1991 Florence Conference, "we first heard of new army recruits in Northern Thailand being tested for HIV. In June 1990, 2% tested positive, but by September 6% tested HIV positive. The current figure among new Thailand army recruits was 17%." At the 1993 Berlin Conference Nopkesorn et al (Abstract PO-C11-2832) reported infection rates of 14% from the upper north, 2% for men from the lower north.

Finally, there is another debate under way as to how hopeful the outlook on HIV/AIDS really is in Thailand. Robert Hanenberg, of the Family Health Institute in Bangkok, reported: "When I published a paper showing that the Thai AIDS Control Program had been a success, there was tremendous resistance to it (privately: no one attacked it in print). The numbers of other STDs fell by more than 85% in five years, and condom use in commercial sex went from 15% to over 90%. But all kinds of unlikely reasons were found to bolster the belief that HIV continued to spread out of control. If I say, 'the Thais have controlled the HIV epidemic,' people look at me like I am crazy. But why not? If I were to say that an epidemic of malaria has been controlled, no one would think twice about it. Why do we need to believe that HIV epidemics cannot be controlled?"

Research Report

RISK AND U.S. SECURITY FORCES

Education about HIV/AIDS high-risk behavior does not necessarily reduce such behavior, and use of modern interactive video in that training is not necessarily the best method. These are the tentative results of two studies of recent U.S. military recruits conducted last year by a team from the Henry M. Jackson Foundation, Wilford Hall Medical Center, and the Military Medical Consortium for Applied Retroviral Research.

U.S. Air Force trainees at the Joint Security Police/Law Enforcement Center at Lackland AFB, 418 males and 118 females, completed anonymous questionnaires, and underwent training from March through May of 1994, either by interactive video, traditional lecture methods, or (as a control) a brief admonition to avoid high risk sex, given as part of a general orientation lecture. The group was chosen "because individuals in this occupational speciality have been shown to be at increased risk for becoming infected with HIV."

The studies showed:

- "a continued high rate of HIV risk behaviors among recent USAF recruits despite widespread knowledge of both HIV risks and prevention measures. It is assumed that these results are not specific to this population but represent a more general trend for people to ignore or deny the risk of HIV infection, and to act in a manner which is inconsistent with their knowledge of HIV and of appropriate prevention measures."
- "the use of interactive video was [no] more effective than either the lecture only or no-treatment control conditions in reducing an individual's risk for HIV exposure. In fact, the only significant effect seemed to favor the lecture condition."

The authors, however, are not ready to abandon video as a tool, are critical of the brevity of the follow-up period of their own study, and are working on a second study, with a four-month follow-up period. They also feel that the effects of training "may become more apparent over time as individuals are forced to confront...high risk sexual behaviors in their own lives."

The two studies were prepared by Robert A Zachary and Alison Schockner of the Jackson Foundation and MMCARR, and Sandra L. KilPatrick, Gerald W. Talcott, and Edna R. Fiedler of the Wilford Hall Medical Center.

Conference Report

Military Medicine: West Africa

Stuart Kingma

First (African) International Medical Conference of the Armed Forces and Police (Organized and Hosted by the Cameroon, 23-24 February 1995)

Approximately 500 representatives of the armed forces, the police and the health professions of 16 countries (mainly French-speaking countries of Africa), together with delegations from several international agencies, gathered in Yaoundé, Cameroon, 23-24 February 1995, for the first ever conference of this type in Africa. The conference was sponsored by the Ministries Defense and Public Health of the Cameroon, and it focused on the theme: Sexually Transmitted Diseases (STDs) and AIDS.

One point became very clear during these two days, if it had not been clear to everyone before this. STDs and HIV / AIDS are major health problems in the police and military populations throughout the African Region, and they are serious preoccupations of the medical services of the armed forces. Just as studies have long shown that the rate of infection by sexually transmitted diseases is often twice, or more, as high among military personnel compared to the situation among their civilian neighbors, so the indications now are that the risks for HIV infection are correspondingly elevated for the armed forces.

A number of the countries present noted that the rates of infection were at alarming levels. In one case, it was found that non-commissioned officers seemed to be the category of personnel the hardest hit. In several countries, it was acknowledged that AIDS had become the leading cause of death among serving military personnel; in at least one country it is responsible for as many as 50% of deaths.

Systematic testing of military personnel, almost exclusively concentrating on testing prior to recruitment, is being practiced in a few countries of the region, although it has not been made a visible policy issue. The reasons offered for such a practice generally have nothing to do with the idea that this might prevent HIV infection from coming in or spreading within the serving forces. It is mainly for economic reasons, and for reasons of sustaining a ready security force. It was stated by one delegation that the military cannot take on HIV-positive recruits since that will oblige them to care for those troops when they fall ill, and they know how high those costs will be. They say that the military budgets are less able to absorb that than the national health budget. They know that those who may be recruited as HIV-positive may have been positive for a number of years already. And they what the associated costs will be as they lose the benefit of the training, the skills and the experience of the troops that become ill and die of AIDS soon after recruitment - and they have to start over with new recruits. It is clear that for countries with high seroprevalence in the civilian population, the option of pre-recruitment testing for the military—already a complex issue with human rights and discrimination aspects—is being revisited for economic and management reasons, and not for poorly-conceived public health reasoning.

The quality of the 60 or more papers offered during this two-day conference was high, giving testimony to the impressive level of study, research and practice to be found among the medical personnel of the police and armed forces of the region.

Some of the participants included: AFRICAN NATIONS: Benin, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Gabon, Guinea, Nigeria, Rwanda, Senegal, Togo, and Tunisia.

NON-AFRICAN NATIONS: Belgium, Germany, Switzerland, and France.

INTERNATIONAL AGENCIES: AIDSCAP, Pasteur Institute and WHO ❑

(CONTACT: Médecin Colonel E. Mpoudi Ngolle, B.P. 334 Yaounde, Cameroon, Tel 00237 22 67 19 Fax 00237 206084)

"Earliest AIDS Case Is Called into Doubt"

New evidence shows that what was believed to be the earliest known case of AIDS may not have been the disease after all. Examination of stored tissue samples taken from David Carr, a man who died in 1959 from mysterious symptoms, prompted two University of Manchester doctors in 1990 to attribute the symptoms to AIDS. When Dr. David Ho, head of the Aaron Diamond AIDS Research Center in New York City, recently tested the samples, he could only isolate HIV from one sample that had been sent to him. Additional tests showed the tissues sent to Ho were from at least two people. In Ho's opinion, there is no longer proof that Carr died of AIDS. Although University of Manchester officials reject Ho's findings, the university is planning further investigations. (*New York Times* (04/04/95)

HIV/AIDS Among U.S. Military Veterans

Sven Groennings

The U.S. Department of Veterans Affairs (VA), which maintains approximately 165 hospitals serving 3 million military veterans annually, treated 17,268 HIV/AIDS patients in 1994. The cumulative number of individuals treated since 1987 exceeds 22,000. The first patient appeared in 1979, and the total did not reach 100 before 1983. Early cases generally were found in patients coming in for other ailments.

There has been and increase of only 1,000 cases in last three years due to: screening practices within the military; providing care to those who contracted the disease while in the military, or those with needs based on poverty; a decline in those who received the disease from transfusions; and a reduction in those—largely from the Vietnam era—whose illness is drug-related. VA hospitals do not serve military dependents. Only 4 percent of VA HIV/AIDS patients are women.

WAR IS HELL

AIDS IS WORSE

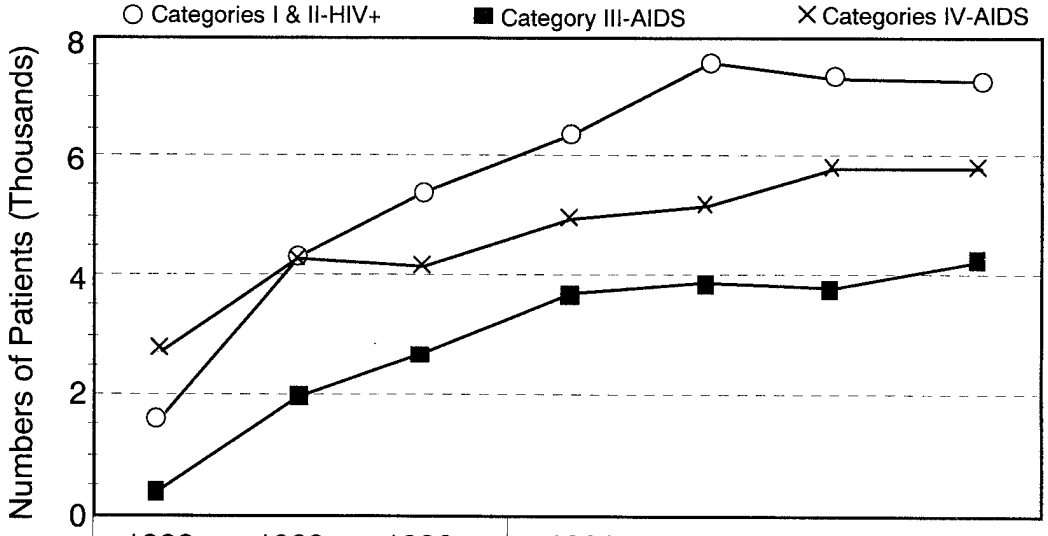
Countries with national health systems tend not to have separate military health programs for veterans. In the U.S., in 1988, Congress mandated the VA to establish and maintain an HIV/AIDS information and training program for staff and patients. The VA has "training-of-trainers" programs for counselors. Since 1988, all VA medical centers have been receiving ongoing video satellite teleconferences featuring programs on HIV and AIDS, as well as quarterly national educational teleconferences. VA hospitals conduct patient health education programs on prevention of HIV infection and have added HIV/AIDS programs for addiction treatment staff. The VA's educational materials include AIDS-in-the-workplace films in Spanish. There are AIDS Clinical Units in Miami, New York city, San Francisco, and West Los Angeles. There is a VA AIDS Information Resource Center in San Francisco. In addition, the VA has 250 AIDS research projects at 35 medical centers; it has 4 AIDS Research Centers.

"It's Time To Fight Again!
The War Is On AIDS
The Enemy Is Ignorance
The Weapon Of Choice Is
Education"

The Veterans Administration has printed posters (see boxes) that convey AIDS education and prevention message. One, which targets the problem of IV drug transmission, states:

"Shooting to kill—If the drugs don't kill you, AIDS will". ❑

NUMBER OF HIV/AIDS PATIENTS TREATED AT VA MEDICAL CENTERS BY FISCAL YEAR 1988 - 1994



	1988	1989	1990	1991	1992	1993	1994
Categories I & II-HIV+	1.627	4.438	5.436	6.476	7.469	7.306	7.222
Category III-AIDS	0.59	1.977	2.828	3.602	3.735	3.572	4.224
CategoryIV-AIDS	2.702	4.338	4.205	4.869	5.006	5.871	5.822
Total	**4,919**	**10,753**	**12,469**	**14,947**	**16,210**	**16,749**	**17,268**

VA National Registry & Boston Development Center (Data as of February 2, 1995)

PUBLICATIONS

■ *The Hot Zone.* By Richard Preston, is a professional writer's account of the 1989 discovery of an Ebola virus agent in crab monkeys shipped from the Philippines to Reston, Virginia (New York: Random House, 1994.)

■ *The Coming Plague: Newly Emerging Diseases in a World Out of Balance.* Laurie Garrett has written a broad review which includes the Ebola episode, but also explores other case studies and the broader implications of new and emerging diseases. (New York: Farrar, Strauss and Giroux, 1994.)

■ *Global Aids Policy.* Edited by Douglas A Feldman of the Department of Psychiatry, University of Miami School of Medicine. Two dozen contributors analyze various policies that have been proposed or adopted in China, Africa, Latin and North America for dealing with HIV/AIDS, and examine implications for international health.

■ *"Disease in Evolution: Global Changes and Emergence of Infectious Diseases."* Proceedings of a conference (November 7-10,1993) sponsored by the Harvard School of Public Health's working group on "New and Resurgent Diseases." Mary E. Wilson, Richard Levins, and Andrew Spielman. New York: New York Academy of Sciences, 1994.

■ *The AIDS Knowledge Base: A Textbook on HIV Disease from the University of California, San Francisco, and the San Francisco General Hospital*

"The AIDS Knowledge Base," is the work of 102 contributing authors, focuses on AIDS as it is presented and managed in the United States. It is intended to be relevant to all geographic regions for a wide range of health care professionals and motivated nonprofessionals. The book's 11 sections address the pathogenesis and management of HIV infection, as well as legal, economic, and ethical issues. Because many of the authors are from San Francisco, however, there is a tendency to base general statements on experience with middle class men. Still, information that is relevant to all persons affected by AIDS is usually included. Some particularly comprehensive chapters are those on the methods of testing for HIV antibody or antigen and on rochalimaea, and the section on the pulmonary aspects of AIDS. (*New England Journal of Medicine* (03/02/95) Vol. 332, No. 9, P. 617; Klein, Robert S.)

■ **"Preventing AIDS: Theories and Methods of Behavioral Interventions"**

"Preventing AIDS: Theories and Methods of Behavioral Interventions," edited by Ralph J. DiClemente and John L. Peterson, is a series of essays detailing behavioral interventions and assessing current research on preventing HIV infection among populations including runaways, heterosexual men and women, and adolescents. The first six chapters describe behavioral-science research methods. These chapters are based on the health-beliefs model, in which change in a person's behavior occurs only if that person perceives a risk and believes that the outcome can be affected through behavior change. In the nine chapters about research on HIV prevention in populations at high risk, the authors accent what is needed and recommend methods to evaluate the outcomes. The editors call for the promotion of self-management to reduce risk at the individual level, and the promotion of sustained changes in social norms through community-level interventions. (*New England Journal of Medicine* (03/02/95) Vol. 332, No. 9, P. 617; Fleming, Patricia.)

■ *Deadly Medicine.* By Thomas J. Moore, is a new book concerning the antiarrhythmic drug Tambocor. Even though it does not directly concern HIV/AIDS, it provides inside information on clinical trials, use of surrogate markers, doctors' ties with drug companies, and the invasive influence of these companies on the medical distribution system. From the Prologue: "This book tells the story of America's worst medical drug disaster. Over just a few years, an estimated 50,000 people died from taking drugs intended to prevent cardiac arrest. After hundreds of thousands of patients routinely took these drugs, a definitive medical experiment proved they did not prevent cardiac arrest as doctors had believed. Instead the drugs **caused** cardiac arrest. Often the effect was so sudden and unexpected that people literally dropped dead while going about their normal lives. The result of this single medical misjudgement about the properties of these drugs produced a death tool larger than United States combat losses in wars such as Korea and Vietnam. If one were to total the death from every commercial airplane crash in the history of U.S. aviation, the sum would not approach the number of deaths from this episode."(published by Simon & Schuster in 1995; ISBN 0-684-80417-4.)

New Publications:

Encyclopedia & AIDS

Garland Publishing, New York, has announced that work has begun on the *Encyclopedia of AIDS: A Social, Political, Cultural, and Scientific Record of the Epidemic*, edited by Raymond A. Smith of the HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute.

The encyclopedia will provide a comprehensive survey of the first fifteen years of the AIDS crisis, with over 300 entries covering transmission, treatment, prevention, epidemiology, pathology, impacted populations, culture and society, politics and activism, policy and law, and international issues.

Anyone who wishes to contribute to the project should direct inquiries to the editor in chief.

Contact: R. A. Smith, *Encyclopedia of AIDS*, PO Box 1788, New York, NY 10025. Tel or Fax: 212-961-0201, E-mail <raysmith@iris.rfinh.org>.

BRIEF REVIEW

FitzSimmons, D.W. and A.W. Whiteside. ***Conflict, War and Public Health.*** (Conflict Study 276, ISSN 0069-8792) London: Research Institute for the Study of Conflict and Terrorism, 1994.

As events in Rwanda, Cambodia, and other areas of upheaval have shown, public health disruptions can be as destructive as any other aspect of war or civil disturbance, and this study offers ample documentation that the problem is currently worldwide.

This study presents the scorecard of global conflicts as of mid-1994. Thirty-four nations, from Algeria to Sri Lanka, have suffered not only military, revolutionary, or terrorist disruption, but have had the accompanying devastation of cholera, dysentery, plague, typhoid, typhus, measles, tuberculosis, pneumococcal infection, malaria, and HIV/AIDS.

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A previous Conflict Study by the same authors, ***The AIDS Epidemic—Economic, Political and Security Implications*** [CS251, May 1992], examined the last subject in detail.

Analyzing the process by which public health is intertwined with civil disturbance, the authors examine the stages by which the complications develop: pre-disaster, pre-impact, impact, relief, and rehabilitation. The consequences, not only in casualties, destruction, and disease, but in the broader dimension of loss of human and economic capital, diverted and wasted resources, are noted; and the authors call for a further "Research Agenda" to explore the problems further.

Bibliography and tables of national, military, and public health data are also included. [Contact: RISCT, 136 Baker Street, London W1M 1FH, Tel: 0171-224 2659; Fax: 0171-486 3064]

AUTHOR'S BIOGRAPHIES

Robert Currie, managing editor of the *Alliance* Newsletter, is a writer and editor based in New York City, USA.

Sven Groennings is the Washington DC representative of the Civil Military Alliance. He has been a professor of Political Science, a member of the US State Department, a staff of officers for a US Senator, and author or editor of five books on European Affairs.

Stuart Kingma, M.D. is an American surgeon with 34 years of experience in international health, beginning with 9 years in a rural hospital in Nigeria. Since 1984, he has been on the staff of the World Health Organization, working in the Global Programme on AIDS since 1992. He is presently working on the team to design the new UNAIDS programme.

Norman Miller, the editor of the *Alliance Newsletter* and *AIDS & Society*, is author of *AIDS in Africa: The Social and Policy Impact*, (with Richard Rockwell). He also serves as a professor at Dartmouth Medical School, USA.

Allan Whiteside is an Associate Professor at the University of Natal, Durban, South Africa and an editor of the international publication AIDS Analysis.

Lt. Col. Raymond Wouters, is co-editor of the *Allilance Newsletter*, a physician in the Belgian army particularly concerned with internal medicine, infectious and tropical diseases.

Rodger Yeager , Professor of Political Science at West Virginia University, USA, has written extensively on AIDS policy issues. He edited the proceedings of the Military AIDS conference in Berlin, 1993 and is a member of the Alliance advisory board.

Call for Brief Articles

The editors of the *Alliance Newsletter* are seeking brief articles, news items, research reports, book notes and up-coming conference notes, to be published in our next issues. (July and October 1995)

TOPICS OF INTEREST

- HIV/AIDS Prevention in Military Settings
- Military Education and Training programs
- Research Findings on Civil-Military Aids Issues
- Issues of Families, Military Children, Child Soldiers
- Issues of Sex Workers in military communities
- Issues of Peacekeeping and AIDS
- Issues of Training in Pre-Deployment Briefings
- Issues of demobilization, AIDS prevention
- Bibliographies and Resource guides

Please send items to: The Editors, The Alliance Newsletter, c/o AIDS and Society, 4 West Wheelock Street, Hanover, New Hampshire, 03755 USA

CALENDAR 1995-1996

MAY 28-JUNE 3
HARARE, ZIMBABWE
Regional Training Seminar WHO/World Bank/ Civil-Military Alliance

JUNE 6
JERUSALEM, ISRAEL
International Conference on AIDS and Hepatitis as Occupational Hazards
Contact: ISAS International Seminars, PO Box 574, Jerusalem 91004, Israel. TEL: 972-2-868124; FAX: 972-2-868165.

JUNE 8-10
BRUSSELS, BELGIUM
Civil-Military Alliance Regional Meeting
(Steering group)

JUNE 26–28
WASHINGTON DC. USA
22nd Annual NCIH Conference Violence as a Global Issue
Contact NCIH Conference Department (202) 833-5903

JUNE 29
WASHINGTON DC, USA
National Council for International Health AIDS Conference Satellite

AUGUST 7-9
WASHINGTON DC. USA
USAID: 3rd HIV/AIDS Prevention Conference
Contact: AIDSCAP, Al Nimocks, Renaissance Hotel Tel: (703) 516-9779

SEPTEMBER 4-15
BEIJING, CHINA
UN 4th World Conference on Women: Action for Equality Development and Peace
Contact: S. Kindervatter, USA. Fax: 202-667-6236

SEPTEMBER 17-21
CHAING MAI, THAILAND
Third International Conference on AIDS in Asia and the Pacific
Fifth National AIDS Seminar in Thailand
Contact Dr. Chanpen Choprapawon, Thailand Health Research Institute National Health Foundation, 1168 Soi Phaholyothin 22, Phaholythin Road, Ladyao, Jautjak, Bangkok 10900. Tel: (66 2) 939-2239, 939-2261, 939-2143, Fax: (66 2) 939-2122

NOVEMBER 15-18
SANTIAGO, CHILE
Tenth Latin American Congress on Sexually Transmitted Diseases
IV Pan American Conference on AIDS,
Contact: Dr. Bianca Ocampos, Organizacion XM, Andresde Fuenzalida 22, Of. 303, Casilla 200, Providencia, Chile Tel: 231 9362, Fax 232 2559.

NOVEMBER 26-DECEMBER 1
JERUSALEM, ISRAEL
9th International Conference on AIDS Education
Contact: Conference Secretariat, PO Box 50006,Jerusalem, Israel Tel Aviv 61500, Israel. Tel (972 3) 514 0014, Fax: (972 3) 660 325/517 5674

DECEMBER 10-14
KAMPALA, UGANDA
9th International Conference on AIDS and STDs in Africa
Contact: AIDS Conference Secretariat, PO Box 6, Entebbe, Uganda. Tel: (256 42) 20297, Fax (256 42) 20608,

JUNE 3-5 1996
BEJING, CHINA
International Congress on Military Medicine

AUGUST 7-10 1996
VANCOUVER, CANADA
XI International AIDS Conference

Civil-Military Alliance to Combat HIV and AIDS

Alliance NEWSLETTER

Volume 1, Number 3 July 1995

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October 1995

- Report on Asia and the Pacific
- New Materials for Training

Worldwide Intelligence Review

The Impact of AIDS on Military Institutions

Is AIDS a Genocidal Agent?
Is AIDS a Weapon of Control?

Testimony in early 1995 before the Senate of the United States revealed a number of problems surrounding military AIDS in developing nations.* When asked to elaborate on how AIDS was impacting the militaries institutionally, General James R. Clapper Jr., Director of the U.S. Defense Intelligence Agency, stated:

> **"HIV and AIDS pose a strategic threat to affected militaries. The HIV pandemic has resulted in losses of skilled manpower and senior leadership among many world militaries. Frequent disruption of leadership through death and disability, including psychologic disability from HIV neurologic syndrome, has fostered unstable environments at senior staff and lower levels. The uncertainty generated by these conditions has resulted in despondency, loss of morale, and corruption, imperiling internal national security and military readiness. Conscripts and other young social groups within militaries remain the highest risk groups for acquiring HIV infection: "mature" epidemics in Africa, for example, show that 60% of new infections are among 15-24 year olds. In militaries with currently high levels of HIV-infection, the script has already been written for disabling future shortages in career military manpower.**

"HIV/AIDS deflects to health care scarce resources that foreign countries otherwise would use for military preparedness. Education and prevention programs, and efforts to compensate for declining "military elite and intelligentsia" and "conscript " pools, place further drains on foreign military resources.

"Ethnic and other social tensions within military organizations, as well as between multilateral forces, have worsened with HIV/AIDS. **The presence of a disproportionate level of HIV infection or AIDS cases in only certain ethnic groups within a given security force fosters the perception of HIV being used as a terror weapon to control certain ethnic groups, or as a genocidal agent.** The stigmas associated with possessing this sexually transmitted disease marginalize and further fragment

Continued on page 4

Report

Violence and Human Rights: NCIH Conference Themes

"Violence as a Global Health Issue" was the theme of the June 26-28 annual conference of the National Council for International Health in Washington, DC. The meeting was followed by a workshop on "HIV/AIDS: International Perspectives on Legal Issues and Human Rights." In his keynote address, UNAIDS Director Peter Piot noted that finding HIV the causal virus of AIDS had led to premature optimism and we now face a "societal catastrophe in slow motion," in which the physical, emotional, and economic impacts of the epidemic are still in their early phases. There are ways to slow down the onslaught, Piot said, but the scale of success has been inadequate, and the problem is out of control in most developing countries. Piot also emphasized that the second decade of fighting the disease will require more partners, including the military sector.

Violence is a central element in vulnerability to HIV/AIDS. Lynel Long, USAID, provided a typology of violence in Bosnia, including gang rapes, public rapes, and forced prostitution, in addition to individual rapes, perpetrated mainly by young, often intoxicated, combatants. She reported that there surely are many hundreds and perhaps thousands of cases. She said that UNPROFOR peacekeeping forces had acquired some of the characteristics of an "occupying army," contributing to the environment for prostitution and sexual harassment. Five UNPROFOR soldiers have been found to be HIV-positive. In Bosnia, no cases of HIV/AIDS are linked to blood supplies, and very few are associated with drugs. Almost all cases are linked to violence, and the basic conditions are in place for an HIV/AIDS epidemic.

Sarah Lai of the Asia Watch/Women's Rights Project reported the complicity of Thai police in the forced trafficking of Burmese girls into Thailand, an activity involving 20,000–30,000 girls, 50-70 percent of whom become HIV-positive. The spectrum of human rights issues ranges from sexual discrimination and slavery to compulsory testing, resulting in dismissal and social stigmatization. Lai said the practice is de facto death sentencing of minors.

The workshops focused primarily on human rights issues that are generic in the context of HIV/AIDS: human rights issues in the testing of vaccines as well as in testing for HIV/AIDS, and the trade-offs between individual rights and the public good. ❑

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News and Notes should be sent to:

Civil-Military Alliance Newsletter
4 West Wheelock Street
Hanover, NH 03755 U.S.A.
Tel: (802) 649-5296
Fax: (802) 649-2331
Telex: 4930372 RPC UI

NEWS BRIEFS

■ **BELGIUM**—Researchers in Belgium have developed a new test for HIV which produces results within days, compared to common testing methods which force a delay of several months. "Usually you have to wait about three months after exposure before knowing whether you are HIV-positive, but with this one we can detect the virus a day or so later," said Professor Jose Remacle of Namur University in Belgium. Remacle's test differs from others in that it checks specifically for HIV, rather than for antibodies, which can only be detected several months after infection. Remacle said his test offers psychological benefits for people worried they might be HIV-positive. His test can also measure the state of advancement of the virus in the body. The test, which costs about $10 per kit, has been marketed in laboratories in Belgium, France, and Italy for the past month. The test's producers are seeking additional distributors in Europe and are hoping to capture the U.S. market. Reuters (03/21/95).

■ **ITALY:** While operating on an HIV-infected patient, an Italian surgeon contracted the virus—representing the first documented case of transmission under such circumstances, said researcher Dr. Giuseppe Ippolito, head of a team at Spallanzani Hospital in Rome that has conducted one of only two major studies on the occupational risk of AIDS among health care workers. Ippolito said the accident took place in a hospital last year when the scalpel cut through the surgeon's glove. The surgeon was immediately tested for HIV. The results were negative, but a follow-up test was positive. "We excluded all other means of transmission," Ippolito said. In Italy, surgical patients are not routinely tested for HIV, and can only be tested, with their consent, when a risk is suspected. Reuters (03/10/95).

■ **SWITZERLAND:** A mandate by the Swiss government to strengthen quality control of blood supplies, which was supposed to go into effect on Jan. 1, is still awaiting approval by the Parliament. Under the order, the Federal Public Health Office will be responsible for ensuring that all blood products and organ transplants undergo all the standardized tests, including those for HIV and hepatitis B and C. Blood donors will be required to fill out a detailed questionnaire. The Blood and AIDS working group recommended the new measures. The Ministry of Interior formed the group after it was determined that blood products supplied to hospitals by the Swiss Red Cross were the source of HIV infection in several patients. The only person to have been charged as the result of these infections is Professor Alfred Haessig, who was director of the Red Cross central laboratory at the time. He is charged with having permitted the preparation and sale of blood derivatives in which HIV contamination was a suspected possibility. *Lancet* (03/11/95) Vol. 345, No. 8949.

HIV Test Cost

Dr. Arthur E. Brown and Dr. Donald S. Burke of the US's Walter Reed Army Institute of Research recently summarized the cost per HIV test incurred by the U.S. Army since 1985. HIV testing in the Army costs less than $2.50 per serum specimen, compared to $15 for screening and $50 for confirmatory testing elsewhere in the nation. For testing active-duty soldiers and military applicants, there is an infrastructure for blood collection, processing, and shipment. The cost per specimen for testing –which includes the transport of specimens, enzyme-linked immunoabsorbent assays (ELISAs), confirmatory testing, and the reporting of results–was $4.41 in 1985 and 1986 and $2.43 in 1994. There is no infrastructure in the U.S. Army Reserve, and costs per specimen are three to four times higher. The Army's experience shows that large-scale HIV testing can be performed at a low cost. Such economic efficiency can also be achieved in the civilian sector, Burke and Brown believe. *New England Journal of Medicine* (04/06/95) Vol. 332, No. 14, P. 963.

HIV As A Weapon of War

Editor's Note

The following item is reprinted from the April *Alliance Newsletter* because of the extensive comment it has received. (Also see article, page 1)

RWANDA–Evidence is emerging that HIV has been used as a weapon of war in the ethnic conflict here. Prior to the outbreak of violence, Hutus charged that they feared the Tutsi would inject them with HIV virus. Rape and concubinage were common during the conflict, with pre-war estimates of HIV infection among soldiers at 45-60 percent, and even higher in the officer corps. According to Dr. Joseph Kaeemera, the new Minister of Health, when women were captured, they were deliberately taken to HIV positive soldiers to be raped. Even though the fighting has stopped, nearly two million Rwandans are in refugee camps, where rape and forced marriages continue. *WorldAIDS*, 3/95.

Country Report: Policy Ambivalence

South Africa: Mandatory Military Testing

Ryan Goodman

In South Africa, 7.5 percent of the sexually active population are HIV positive, with certain provinces reaching levels of 14.5 percent. Thus, according to the Department of Health, 1.3 million South Africans currently have HIV. Such a crisis necessitates government haste. In this climate, the burden of human rights requires government to fight the disease, not the people with it.

On 6 June 1995, the South African National Defence Force (SANDF) announced a new HIV and AIDS policy. Existing Permanent Force members are now subject to a mandatory HIV test if "clinically indicated." If an SANDF member has HIV but is asymptomatic, a medical board is convened to decide on the matter. Such individuals must undergo an annual medical examination to detect for signs or symptoms of ARC and AIDS. Members with full-blown AIDS or ARC are restricted from combat duties, contact sports, donating blood, flying duties, parachuting, and diving. Additionally, "the member's immediate family will also be screened as soon as he tests positive for AIDS."

All prospective recruits must undergo a mandatory HIV test from which "seropositivity is regarded as a disqualification to appointment." Notably, this HIV exclusion does not apply to the SANDF's ongoing integration of approximately 36,000 troops from revolutionary and auxiliary forces, including Umkhonto We Sizwe (the former ANC military wing, the Azanian Peoples Liberation Army' and units from the previously nominally-independent homelands.

Due to the unique independence of South Africa's executive departments, the SANDF policy does not represent a unified position of the presidential branch. In fact, other departmental authorities have responded in official opposition to the SANDF.

A joint letter of concern was submitted to the Minister of Defense and signed by the Director of the Department of Health's HIV/AIDS and STD Programme, members of the National AIDS Convention of South Africa (the coordinating body responsible for drafting the government-approved National AIDS Plan, and representatives from leading HIV/AIDS human rights organizations. The letter states that the SANDF policy:

- violates both the National AIDS Plan and the Minister of Health's public condemnation of pre-employment testing
- abridges the new constitution's provision which expressly prohibits unfair discrimination on grounds of disability
- contravenes the military's special role in upholding and defending the constitution
- "undermines the national effort to reduce HIV transmission and to lessen the impact of the AIDS epidemic."

The SANDF's policy is not the first attempt to remove HIV-positive personnel from the armed forces. According to formal grievances filed in 1994, individuals in basic training have been subject to testing conducted without their knowledge, to disclosure of positive results to the entire troop, and discharge issued on grounds of HIV status alone. ❑

The Impact of AIDS on Military Institutions

Continued from page 1

affected societies, including military societies. Societies already have begun to castigate their own and foreign militaries as carriers of the disease, with problematic consequences for political and military alliances around the globe. Several instances have occurred wherein governments have stipulated that foreign troops may not enter their countries if these forces are not certified as HIV-seronegative.

"Movements of people owing to mobilization, civil conflict, and unrest, are recognized as the key to the spread of HIV. Those who are infected and fall ill return home, placing a double burden on the home-based force. Military planners must squarely face the realities of AIDS-related attrition during prolonged military activities.

"Foreign governments confront several military-specific HIV/AIDS questions:

"1. Should HIV-positive persons be recruited into the military?

"2. What is the full impact on society of demobilization—in addition to the special dangers created for the civilian population, can demobilized military personnel be used as a cadre of workers to promote HIV/AIDS prevention programs?

"3. Are there differences in access to medical treatment for military versus civilian populations, and, if so, should these differences be permitted to continue? Decisions here can profoundly affect ethnic and social tensions within the military, and the greater society.

"4. What is the appropriate role of the military if civilian strife emerges from the HIV/AIDS pandemic?" ❑

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* " Worldwide Intelligence Review." Hearing before the Select Committee on Intelligence of the U.S. Senate, 104th Congress, January 10, 1995. Washington, DC: U.S. Government Printing Office, 1995.

Country Report: Issues of Consent and Testing

Argentina: Major Military AIDS Decree

Sven Groennings

Everywhere in the world, policies pertaining to HIV/AIDS testing in military and police forces are under discussion. We call to your attention Argentine President Carlos Menem's executive decree, which **exempts** the medical services of the armed forces and security forces from obtaining **prior consent** to screen for HIV. The decree extends this exception to all permanent and civilian personnel of the armed and security forces and to anyone who provides services to such personnel under any circumstances.

This extraordinary decree, justified in Argentina by special circumstances that include peacekeeping, is of interest to readers who are concerned with HIV/AIDS policy for military and police forces, including the criteria for implementation, and policies pertaining to thosel found to be HIV-positive. [See also, parallel issue on South Africa, pg. 4)

BUENOS AIRES

Pursuant to Law 23.798 and Decree Nº 1244/91 and

CONSIDERING:

That Article One of law 23.798 declared that the fight against AIDS was in the National interest, and Article Two guarantees the dignity and privacy of infected individuals.

That Article Five of the same Law calls for the need for regulating the measures to be followed regarding the populations of closed and partially closed institutions, establishing guidelines for screening infected persons, for preventing the spread of the virus, the control and treatment of the sick and the surveillance and protection of involved personnel.

That pursuant to Article Six of Decree Nº 1244 of 1 July 1991, implementing the said Law, medical professionals must obtain a subject's prior consent in order to determine diagnostic measures.

That the activities of the Armed and Security Forces present particular characteristics, such as being exposed to risky situations involving a great number of accidents, the need for their active blood banks, participation in Peacekeeping Operations and other external missions, in countries where there is a risk of infection of AIDS.

That it is therefore necessary to adopt regulations which take into account the specificity of the Armed and Security Forces.

This Law is adopted by virtue of the authority vested in the National Executive Power in Article 99, Section 1, of the Constitution of the Nation of Argentina.

Now then,

THE PRESIDENT OF THE NATION OF ARGENTINA HEREBY DECREES:

Article One—The medical services of the Armed Forces and Security Forces and participating medical professionals are exempt from the requirement of obtaining the prior consent of subjects to carry out the studies concerning the screening of the virus which causes AIDS, as provided in Article Six of Decree Nº 1244 of 1 July 1991.

Article Two—This exception shall extend to all permanent and civilian military personnel of the Armed and Security Forces and to all other personnel who provide services to the same under any circumstances.

Article Three—Communicate, publish, entrust to the "Dirección Nacional del Registro Oficial" and send to the archives.

[SIGNED]
CARLOS SAUL MENEM
THE PRESIDENT OF THE NATION

East and Central Africa

Seven-Nation Meeting on Military AIDS

Stuart Kingma and Norman Miller

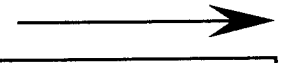
Delegations from seven countries of Eastern and Southern Africa met in Harare, Zimbabwe, at the end of May 1995, for a one-week Regional Training Seminar on "AIDS Prevention and Military Populations." The seminar was designed to examine a number of policy issues and technical aspects important for the development of effective AIDS programmes within the military, and to examine how these efforts within the armed forces could be better coordinated with their own national (civil) AIDS programs.

Co-organized by the World Health Organization's Global Programme on AIDS, the World Bank Economic Development Institute, and the Civil-Military Alliance to Combat HIV and AIDS, in consultation with the United Nations Department of Peace-Keeping Operations, the Seminar attracted seven-person delegations from Botswana, Kenya, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe. The high-level delegations included officials from the Ministries of Defence, the military medical and nursing services, and the civil national AIDS programmes.

The debate on policy issues was dynamic—searching for new solutions to the dilemmas posed by the epidemic for the armed forces—and, on social and cultural issues, the discussion provided a close examination of the particular vulnerability of the men and women in the military. It was acknowledged that there was much work to do in order to achieve a fully effective AIDS education effort in most armed forces, and in order to develop close and cooperative working relationships with the civil AIDS programmes. The heads of the national delegations consulted together on several occasions to draft and finalize their observations, conclusions, and recommendations.

One of the most important conclusions agreed upon by all heads of delegations was the necessity for urgent follow-up. They recommended the convening of a high level policy workshop of the authorities of the defence sector and the civil National AIDS Programme of these seven countries with the purpose of examining the nature and the adequacy of the military's response to this epidemic and sensitizing them to the need for strengthening the national response among the military as well as in the civil arena. This would allow the authorities to consider the technical aspects of HIV prevention policy and practice that were presented and debated during the seminar with the aim of strengthening the national military AIDS programmes, and of finding ways for the military and civil AIDS programmes of each country to collaborate more closely.

The Principal Secretary of the Ministry of Defence of Malawi offered to host the follow-up meeting with the support of the World Bank and WHO. At the end of the seminar, the delegations affirmed their intention to implement the decisions they had taken as "the way forward": "We believe that the recommendations (agreed in this seminar) can make an essential contribution to the challenge that our nations face in the fight against AIDS. Our national military readiness and our common well-being depend on this."



U.K. Conference On "Regulated Communities"

The Royal Society of Medicine of the United Kingdom will host a one day conference on "HIV/AIDS in Regulated Communities" on Wednesday, September 27, 1995, at 1 Wimpole Street, London, W1M 8AE.

Following a brief presentation on the clinical and scientific aspects of HIV/AIDS, the conferees will focus on problems in prisons, the armed forces, and civil aviation.

Lt. Col. Raymond Wouters of Belgium, a member of the Alliance Steering Committee, will give an overview of "Armed Forces Activity and HIV," and Col. Donald S. Burke, of Walter Reed Army Institute of Research, will describe "The U.S. Experience."

Afternoon workshops will focus on "Meeting Clinical Needs?," "The Right to Know and Confidentiality," "Management Issues for HIV-Positive Workers," and "Interface with the Outside Community."

Registration forms may be requested from Nicole Taub, Forums Office, The Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE, or Fax (0171) 290 2989. Telephone inquiries should be made to Lisa Spicer in the Forums Office, 0171 290 2900, extension 4936.

For further information contact:

Civil-Military Alliance to Combat HIV and AIDS
4 West Wheelock Street
Hanover, New Hampshire 03755, USA.

"AIDS PREVENTION IN MILITARY POPULATIONS"

CONCLUSIONS AND RECOMMENDATIONS

made by delegates from

BOTSWANA, TANZANIA, KENYA,UGANDA, MALAWI, ZAMBIA, and ZIMBABWE

to the AFRICA REGIONAL TRAINING SEMINAR held

28 May to 2 June, 1995, Harare, Zimbabwe

co-organized by:

ECONOMIC DEVELOPMENT INSTITUTE / WORLD BANK

WHO GLOBAL PROGRAMME ON AIDS

CIVIL–MILITARY ALLIANCE TO COMBAT HIV AND AIDS

in consultation with

UNITED NATIONS DEPARTMENT OF PEACE KEEPING OPERATIONS

I. OBJECTIVES OF THE SEMINAR:

1. To cooperate in the development of an educational strategy for the prevention and care of HIV / AIDS and STDs within military populations. including the development of appropriate briefing and training materials.

2. To address training needs for the military commanders and officers who are responsible for the development and implementation of AIDS prevention and care programmes for their own forces, including the special needs of contingents deployed outside their own countries.

3. To address the training-of-trainers needs of the participating countries, keeping in mind the fact that participating countries are those in the forefront of contributing military personnel for United Nations Peace-Keeping Operations.

4. To agree on follow up activities that have been identified in the course of the seminar and that will be pursued, first of all, through a strengthening of military AIDS programmes and by enhancing their cooperation with the civil national AIDS programmes. These will also be pursued through common action, including measures which will strengthen linkages between countries, networking, development of learning materials, and joint programme development among participating countries.

Participants to this seminar were drawn from the senior members of the Medical Services of the Armed Forces, senior officers of the Ministries of Defence, and staff of the civilian National AIDS Programmes of these seven countries.

II. OBSERVATIONS AND COMMON FINDINGS DRAWN FROM THE PRESENTATIONS AND CONTRIBUTIONS OF THE PARTICIPANTS.

1. The continuing progression of the HIV epidemic in the world and in our own countries is a matter of real concern. and demands our vigorous attention. Of particular concern is the impact of the epidemic that we are witnessing in our armed forces, their families and their communities. This concerns the prevalence of sexually transmitted diseases (STDs) as well as infection with HIV and the number of cases of AIDS.

2. We recognize the vulnerability of women and youth to HIV / AIDS infections and we feel that measures should be put in place to address this situation. We affirm the importance of empowering women and youth, in the military and in the civil society, to be able to make choices about sex and sexuality in HIV and STD prevention.

3. We take note of the critical role that armed forces from all parts of the world are now playing in conflict resolution and peace-keeping, and this includes contingents of very substantial size contributed by our countries, as well as those troops sent from industrialized countries.

4. In connection with the peace-keeping role of our troops, we examined the very real problems that sexually transmitted diseases are causing in these missions, and these are significant issues for the contingents from both industrialized and developing countries.

5. This was an unprecedented opportunity for us to sit and consult together on the complex policy issues in AIDS prevention that face our militaries. For this, we wish to express our gratitude, first of all, to the Government of Zimbabwe for hosting this Regional Seminar, and for all the support it has given. We also want to state our appreciation to the organizers of the seminar: the World Bank/ Economic Development Institute, the World Health Organization/Global Programme on AIDS, the Civil–Military Alliance to Combat HIV and AIDS, and the United Nations Department of Peace-Keeping Operations.

8. We hope to honour the investment we have ourselves made during this week of policy review and technical discussion. We intend to build upon what we have learned. It is in this spirit that we have made a number of recommendations that will help to extend the cooperation, coordination and joint activities that our Armed forces have with the civil National AIDS Programmes in our countries, and to make the best use of our human and technical resources.

7. We affirm the importance of collaboration between the civil and the military AIDS Prevention programmes. However, we recognize that militaries all over the world, consider certain information and data as confidential.

III CONCLUSIONS AND RECOMMENDATIONS

1. We recommend the convening of a high-level policy workshop of the authorities of the defence sector and the civil National AIDS Programme of our seven countries. The purpose of this workshop will be to re-examine the nature and the adequacy of our response to this epidemic, and to consider the technical aspects of HIV prevention policy and practice that were presented and debated during this seminar. This would be with the aim of strengthening our national military AIDS programmes and of finding ways for the military and civil AIDS programmes of each country to collaborate more closely.

2. At this high-level policy workshop and in future planning in our respective countries, we recommend that we explore how we may reinforce our respective national responses through concerted efforts and inter-country action.

3. We recommend that our countries hold this policy workshop in the fourth quarter of 1995. We strongly urge that our Governments respond to the expressed willingness of the Economic Development Institute of the World Bank, and the other cosponsors, to help convene this workshop, and to provide some of the resources that will be required to hold the workshop.

4. We strongly recommend to our Governments that they make a contribution to the convening of such a workshop.

5. We also recommend that we begin consultation among ourselves at the technical level, with a view to consider the formulation of draft proposals of projects that could give concrete expression to the understanding we have reached here. These initiatives can usefully be directed towards capacity-building within the militaries as well as in the civil programme. Areas of interest for this project development will include the training of personnel, inter-country-cooperation in development of IEC activities, training in management skills such as planning and evaluation, and research. An essential element in realizing these goals will be the mobilization of resources and funding.

6. As this level of inter-country cooperation matures we will take the necessary initiatives to approach appropriate partners that may support us in the realization of these proposals through technical cooperation, financial support, and partnership in execution. In this respect, we will be contacting the WHO, UNAIDS, the World Bank, UNDP, UNICEF, agencies such as AIDSCAP and Population Services International, and NGOs concerned with these issues.

7. We believe that our inter-country cooperation should include both civil–military working relationships, as well as military-to-military cooperation. Specifically, we recommend the relevant institutions in our countries to:

a. exchange policy documentation, field operational manuals, standard operating procedures, medical manuals, and other relevant documentation related to STDs and HIV in military populations; and

b. generate and exchange learning and training materials, training processes and programmes, and train-the-trainer manuals that deal with STDs and HIV prevention, counseling, and care.

IV. THE WAY FORWARD

We believe these recommendations can make an essential contribution to the challenge our nations face in the fight against AIDS. Our national military readiness and our common well-being depend on this.

Within our countries, we will find the way forward through intensifying our efforts, and through closer cooperation between our militaries and the civil National AIDS Programmes.

Furthermore, as neighbouring countries in a region hit so hard by the epidemic, we cannot continue to "go it alone," and believe that inter-country initiatives are now appropriate.

We understand that the organizers of this Seminar will be getting in touch with our respective Governments to determine what their response to these recommendations will be and will continue to support us as we map out the way forward.

Harare, Zimbabwe, 1 June 1995

Regional Report

Military AIDS: Latin America

Sven Groennings

In Lima, May 22-26 the Committee for the Prevention and Control of HIV/AIDS in the Armed Forces and National Police of Peru (COPRECOS), hosted the First International HIV/AIDS Seminar for Latin American Military Forces and Police. Ther were presentations by medical-military representatives of **Argentina, Bolivia, Brazil, Cuba, Honduras, Paraguay, Peru, Uruguay**, and **Venezuela**, who shared data and strategic thinking. Also attending were representatives from **Chile** and the **Dominican Republic.**

Complementing the individual country presentations were general presentations on epidemiology and clinical aspects as well as other subjects. Speaking for the Pan American Health Organization (PAHO), Dr. Oscar Mujica of Peru outlined the global dimensions of the disease and an analysis of modes of transmission. Also from PAHO, Jose Romero of Mexico discussed educational interventions, Sven Groennings of the United States spoke on the Civil-Military Alliance's mission and activities, providing publications end inviting those present to become members, He also discussed the American Red Cross training program, which is available in Spanish, and the programs of the U.S. Navy and U.S. Air Force.

Romero, who had come from a reunion of approximately 20 Mexican NGOs working with AIDS, wanted to encourage the NGOs of Peru and other countries to: "work with society's other players (the state, the military forces, etc.) so that they will learn to avail themselves of HIV/AIDS NGO leaders' real strengths and "work toward evaluating their own strengths and enter into a dynamic collective with strong confidence, self-affirmation and exchange of benefits. Internal appraisal permits recognition of society's other players, opening the door to the utilization and benefit of their resources and talents.[1]

Peru presented its integrated 3-year plan for all of its armed forces and its national police (Comite de Prevencion y Control del VIH/SIDA de las Fuerzas Armadas y Policia Nacional de Peru — COPRECOS, Plan Trienal 1995-1997, 1995, 195 p.; Navy section to be added), developed under the leadership of COPRECOS's President, Medical Colonel Juan Alva Lescano. This is a plan for an intermediate period, in effect a first plan. Developed across two years with PAHO's technical collaboration, it incorporates some activities already begun. It is informed by epidemiological data and survey research on risk behavior. In its comprehensiveness, depth, and organization, it may be considered a model for other countries.

The plan presents a common set of objectives for all the armed and police forces: securing of safe blood supplies, arranging availability of testing, improving the epidemiological information system and laboratory procedures, providing psycho-social care and family counseling, and developing education programs. The plan designates lead hospitals and calls for beginning education programs within the military schools and training centers. It defines projects to be implemented toward each objective. For each it specifies organizational responsibility, success indicators, documentation requirements, and budget requirements.

Results of the meeting. The Lima participants agreed upon these findings and conclusions: HIV/AIDS is a serious health problem affecting the armed forces and police forces of Latin American countries, and notably 20-40 year-olds, a population central to economic productivity; transmission is most frequently heterosexual; uniform management criteria for dealing with those affected do not exist; most of the countries lack a central organization for HIV/AIDS prevention within the military and police, and there is no flow of communication between the various organizations; screening has been shown to be an adequate diagnostic method; some of the countries' militaries and police conduct screening through other institutions' laboratories; epidemiological vigilance is crucial to the determination of prevalence; active-duty military and police personnel are an important source of blood supplies in normal circumstances and still more in special contingency situations; in most of the participating countries, infected personnel continue in active service in re-classified status.

The meeting recommended: creating entities parallel to Peru's COPRECOS in every Latin American country; creating a regional coordination with a rotating president; holding annual meetings with a rotation of host countries to promote exchange of personnel and to resolve new problems; elaborating unified protocols regarding diagnostics, treatment, and research; creating a permanent secretariat in Peru to develop a COPRECOS newsletter for the Latin American countries; and accepting the abbreviation COPRECOS for the organizations to be created in this framework.

Accordingly, the participants from the 11 countries issued the Declaration of Lima on May 26. This Declaration: (1) recognizes that the HIV/AIDS epidemic is a health problem of great impact in the armed forces and police and can endanger the socio-economic development and integrity of the countries represented; (2) commits the representatives to uniting in the struggle against this scourge; (3) invites representatives of the armed forces and police of the rest of the Latin American countries to join the Lima group in this pledge; and (4) recommends the creation of committees of HIV/AIDS prevention and control (COPRECOS) in all the signatory countries as well as the creation of a collective entity to assist Latin American governments and military and police authorities. ❑

1. In January, PAHO and the National Council for International Health (U.S.) co-sponsored strategic planning meetings in Bogota, Columbia, for five Latin American NGO networks. PAHO and Mexico's CONASIDA will co-sponsor a Latin American meeting in Mexico City, October 18-20, 1995, on legislation and human rights related to AIDS for government officials, NGOs, and academics.

Alliance Business: Planning for New Initiatives

The Alliance's Steering Committee met in Brussels, June 8-9, 1995, at the invitation of Major General Marc De Coninck, Alliance co-chair. The purposes were to review Alliance progress since the organizing meeting in November, 1994, to further clarify and develop the aims and objectives of the Alliance as they are to be reflected in its policies and program of work, and to delineate planning processes for activities in the European region, including Eastern Europe.

Steering committee members attending were General De Coninck, Belgium; Admiral Anthony Revell, United Kingdom, co-chair Europe; Brigadier General Raffaele D'Amelio, Italy, co-chair Europe; Professor and Lt. Col. Souleymane Mboup, Senegal, co-chair Africa; Ms. Elizabeth Reid, director, UNDP HIV/AIDS and Development Programme; Professor Norman Miller, Director of the Alliance; Dr. Stuart Kingma, WHO Global Programme on AIDS; and Lt. Col. Raymond Wouters, AIDS Coordinator of the Belgian Military Medical Service and co-editor of the Alliance Newsletter. Also attending was Dr. Sven Groennings, Director of the Alliance Resource Center in Washington. Dr. Ben Mbonye of Uganda is also a member of the committee.

The Committee decided: (1) to explore possibilities for moving the Alliance's headquarters from the U.S. to Europe in mid or late 1996/early 1997, and acquiring legal status in a European country; (2) to begin a French-language edition of the Alliance Newsletter; (3) to present proposals to European international organizations toward funding Alliance activities in Europe and on other continents; (4) to broaden the representation of Asia and Latin America on the Steering Committee so that there will be two members from each region.

The Alliance questionnaire on "HIV/AIDS Prevention, Testing, and Care in Military Medical Practice," developed by General D'Amelio and Colonel Wouters, will be sent to 100 countries. WHO has offered to analyze the responses on behalf of the Alliance and to ensure that confidentiality is guaranteed. The Alliance will ensure that the results will be sent to all those responding and will be published in the *Alliance Newsletter*.

The steering Committee heard reports on the WHO/World Bank Alliance African Training Seminar on HIV/AIDS Prevention in Military Populations held in Harare, Zimbabwe, May 28-June 2, 1995; the First African International Medical Conference of the Armed Forces and Police, hosted by Cameroon, February 23-24, 1995; and the First International HIV/AIDS Seminar for Latin American Military Forces and Police, hosted by Peru in Lima on May 22-26, 1995. The activities of the Alliance to date have increased understanding of HIV/AIDS in military populations, and of the need for a civil-military response. Networks are being built. The Alliance is also exploring how it can best assist in the strengthening of national and intercountry capabilities to combat HIV and AIDS.

The next meeting of the Steering Committee will be in Geneva in early October.

Zambian Military AIDS Prevention

Well aware that the nature of military operations forces personnel into long periods of absence from home and into sexual relationships that are often risky, the Defence Force Medical Services of Zambia, which serves the army, air force, national service, police, and prisons, has developed an HIV/AIDS Awareness Programme. The Programme operates in four areas: counseling, sensitizing, peer education, and home based care. Brigadier General J.B. Simpungwe has summarized these areas as follows:

- **Counseling.** At least two or three trained counselors, either doctors, nurses, or clinical officers serve in every unit/station, and the goal is to train others, in all ranks, and even spouses, so that counseling can eventually extend to peer level.
- **Sensitizing.** Workshops for the military hierarchy, ranging from commanding officers and company commanders to middle-rank officers, teach awareness and understanding of the psychological and social aspects of HIV/AIDS.
- **Peer Education.** The sensitivity workshops were followed by training of peer educators at unit level, including all ranks, spouses, and families.
- **Home Based Care.** Given the long bed-occupancy of AIDS patients, this aspect of the Programme is a very important one. After a very successful beginning, supported by local civilian home-based services, lack of resources, i.e., food, clothing, and transport, has forced this part of the Programme into a holding pattern.

Plans are underway to extend the Programme to the youth of the nation. (For information contact: Defense Force Medical Services, P.O. Box 31931, Lusaka, Zambia. Fax: 263883

Publications

BRIEF REVIEWS

Gurr, Ted Robert. Minorities at Risk: A Global View of Ethnopolitical Conflicts. Washington, DC: U.S Institute of Peace, 1994.

Surveying over 200 politically active ethnic, racial, and communal groups, the author examines how conflicts between minority and localized societies arise and develop. It is a basic contribution to the study of nationalism, ethnic conflict, and Minorities at Risk.

Hirsch, John L. and Robert B. Oakley. Somalia and Operation Hope: Reflections on Peacekeeping and Peacemaking. Washington, DC: U.S. Institute of Peace, 1995.

The authors argue that despite renewed violence, humanitarian aspects of the peacekeeping operation are in place, and that substantial good was done during the intervention. They explore the differences in policies held by the U.S. and the U.N., and raise important questions about the limitations of peacekeepers in nation building as well as how such operations ought to be conducted.

Sahnoun, Mohamed. Somalia:The Missed Opportunities. Washington, DC: U.S. Institute of Peace, 1994.

Part memoir and part case study, this book shows how the tardiness and eventual failure of multinational intervention led to further deterioration in the politics, resources, and spirit of the country. Sahnoun also discusses how the United Nations might better promote stability and provide humanitarian relief in future peacekeeping operations.

New European Commission Report

Action: *The EC's Response to HIV/AIDS in Developing Countries*. 2nd. Ed. (Brussels: Commission of European Communities, 1994), 28 pages.

Interventions developed at the community and bilateral levels make the Europe of the twelve the most important donor in the global fight against HIV/AIDS. This booklet explains what the European Commission has done and is doing, why, on what principles, how much it costs, and describes the programs and countries which have benefited from EC support. (Address: Commission of European Communities, Rue de la Loi 200, B-1049 Brussels, Belgium. Tel. + 32 2 235 11 11).

WHO PUBLICATIONS

The World Health Organization has published over 40 books and videos covering the many aspects of prevention and control of HIV/AIDS.

Publications are available from WHO sales agents in many countries, or directly from WHO, 1211 Geneva 27, Switzerland. Fax (41 22) 791 48 57. [* denotes price in Swiss francs for orders from developing countries]

The following titles may be of interest to members of the Alliance:

The Global AIDS Strategy. 1992, 23 pages; ISBN 92 4 1210117, available in English, French, and Spanish. US $8.10, Sw fr 9/ 6.30*.

Guidelines for the Clinical Management of HIV Infection in Adults. 1991, 86 pages; English and French. US $11.70, Sw fr 13/9.10*.

AIDS in Africa - A Manual for Physicians. P. Piot et al., 1992, 125 pages, ISBN 92 4 154435 X; English. US $14.40, Sw fr 16/11.20*.

Guidelines for Counselling about HIV Infection and Disease. 1990, 48 pages, ISBN 92 4 121008 7; Arabic, English, French, Spanish. US $9.90, Sw fr 11/7.70*.

AIDS Prevention through Health Promotion - Facing Sensitive Issues. 1991, 78 pages ISBN 92 4 156144 0; English, French, Spanish. US $14.40, Sw fr 16/11.20*.

Prevention of Sexual Transmission of Human Immunodeficiency Virus. 1990, 27 pages, ISBN 92 4 121006 0; Arabic, English, French, Russian, Spanish. US $7.20, Sw fr 8/ 5.60*.

Safe Blood and Blood Products. Distance Learning Materials. 1993, five manuals, 647 pages; English. US $108, Sw fr 120/84*.

Guidelines for the Organization of a Blood Transfusion Service. Ed. By W.N. Gibbs and A.F.H. Britten. 1992, 150 pages, ISBN 92 4 154445 7; English, French, Spanish. US $22.50, Sw fr 25/17.50*.

Guidelines on AIDS and First Aid in the Workplace. 1990, 12 pages, ISBN 92 4 121007 9; Arabic, English, French, Russian, Spanish. US $4.60 Sw fr 4/2.80*.

Monitoring of National AIDS Prevention and Control Programmes — Guiding Principles. 1989, 27 pages, ISBN 92 4 121004 4; English, French, Spanish. US $7.20, Sw fr 8/ 5.60*.

Ethics and Law in the Study of AIDS. Ed. By H. Fuenzalida-Puelma, A.M. Linares Parada, and D. Serrano LaVertu. PAHO Scientific Publication No. 530. 1992, 273 pages, ISBN 92 75 11530 3; English, Spanish available from PAHO. Sw fr 52/36.40*.

CALENDAR 1995-1996

SEPTEMBER 4-15
BEIJING, CHINA

UN 4th World Conference on Women: Action for Equality Development and Peace
Contact: S. Kindervatter, USA. Fax: 202-667-6236

SEPTEMBER 17-21
CHIANG MAI, THAILAND

Third International Conference on AIDS in Asia and the Pacific
Fifth National AIDS Seminar in Thailand
Contact Dr. Chanpen Choprapawon, Thailand Health Research Institute National Health Foundation, 1168 Soi Phaholyothin 22, Phaholythin Road, Ladyao, Jautjak, Bangkok 10900.
Tel: (66 2) 939-2239, 939-2261, 939-2143, Fax: (66 2) 939-2122

NOVEMBER 15-18
SANTIAGO, CHILE

Tenth Latin American Congress on Sexually Transmitted Diseases
IV PanAmerican Conference on AIDS,
Contact: Dr. Bianca Ocampos, Organizacion XM, Andresde Fuenzalida 22, Of. 303, Casilla 200, Providencia, Chile Tel: 231 9362, Fax 232 2559.

NOVEMBER 26-DECEMBER 1
JERUSALEM, ISRAEL

9th International Conference on AIDS Education
Contact: Conference Secretariat, PO Box 50006, Jerusalem, Israel Tel Aviv 61500, Israel. Tel (972 3) 514 0014, Fax: (972 3) 660 325/517 5674

DECEMBER 10-14
KAMPALA, UGANDA

9th International Conference on AIDS and STDs in Africa
Contact: AIDS Conference Secretariat, PO Box 6, Entebbe, Uganda. Tel: (256 42) 20297, Fax (256 42) 20608,

JUNE 3-5 1996
BEIJING, CHINA

International Congress on Military Medicine
(exact date to be determined)

AUGUST 7-10 1996
VANCOUVER, CANADA

XI International AIDS Conference

AUTHORS' BIOGRAPHIES

Ryan Goodman is associated with the AIDS Law Project Center for Applied Legal Studies, University of Witwaterstrand, South Africa.

Sven Groennings is the Washington, D.C. representative of the Civil Military Alliance. He has been a professor of Political Science, a member of the US State Department, a staff officer for a U.S. Senator, and author or editor of five books.

Stuart Kingma, M.D., is an American surgeon with 34 years experience in international health, beginning with nine years in a rural hospital in Nigeria. Since 1984, he has been on the staff of the World Health Organization.

Norman Miller, the editor of the *Alliance Newsletter* and *AIDS & Society*, is author of *AIDS in Africa: The Social and Policy Impact*. He also serves as a professor at Dartmouth Medical School, USA.

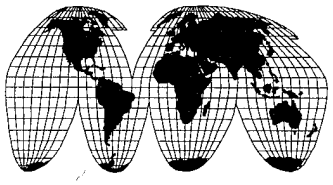
Call for Brief Articles

The editors of the *Alliance Newsletter* are seeking brief articles, news items, research reports, book notes and up-coming conference notes, to be published in our next issue.

TOPICS OF INTEREST

- HIV/AIDS Prevention in Military Settings
- Research Findings on Civil-Military Aids Issues
- Issues of Families, Military Children, Child Soldiers
- Issues of Sex Workers in military communities
- Issues of Peacekeeping and AIDS
- Issues of demobilization, AIDS prevention
- Bibliographies and Resource guides

Please send items to: The Editors, The Alliance Newsletter, c/o AIDS and Society, 4 West Wheelock Street, Hanover, New Hampshire, 03755 USA



Civil-Military Alliance to Combat HIV and AIDS

Membership List
January 1995

ARGENTINA

. Lt. Col. Pedro Pablo Di Spagna, Chief, Immune Deficiency Ctr, Army Medical Ctr, Hospitae Militar Central, Avenida Luis Maria Campos #726, 1426 Buenos Aires, +541-7723052

BELGIUM

. R. Colebunders, M.D., Institute of Tropical Medicine, Nationalestraat 155, 2000 Antwerp
. Med Gen Marc J. De Coninck, Chief of Staff, Medical Service Belgian Armed Forces, Quartier Reine Elizabeth, Everestraat 1, B 1140 Brussels, +32 2 7013102, +32 2 7013071 FAX
. Jean-Luc D'Gala, 145 Val des Seigneurs, 1150 Brussels
. Dr.Med Lt. Col. Raymond M.A. Wouters, Chief, Md - CDC, Military Hospital Queen Astrid, Bruynstraat 1120 Brussels, +32-2-2680050, ext 2210, +32-3-2162867 FAX, Email: Rwouters@medconf.be

BRAZIL

. LTC Milton Braz Pagani, M.D. Principal, Pathology and Cytology Laboratory, Central Hospital of the Army, USAMRU-Brazil, Am. Consul - Rio, APO AA 34030, +55-21-2286195, +55-21-2481335 FAX

BULGARIA

. Radka Argirova, Assistant Professor, Central AIDS Laboratory, Sofia 1233, +35-92-695110 FAX

BURKINA FASO

. Neen B. Alrutz, Bureau Sante, Population et Nutrition, U.S.A.I.D., B.P. 35, 01 Ouagadougou, +226-306723/+226-333219 (Res)
. Cpt. Joseph Drabo, Specialiste in Medecine Interne, Service de Santé des Forces Armées du, Brukina Faso, 01 BP 909 Ouagadougou, +226-314769, +226-311357 FAX

CAMEROON

. Lazare Kaptne, M.D., Ph.D., Professeur, Dept of Haematology, University of Yaourdi, +237-231052, 237-209075 FAX
. Lt. Col. Ngolé Eitel Mpoudi, M.D., Chef Program National, ULS-CNLS Yaourdé, Ministry of Defense, B.P. 334 Yaourdé, +237-206084, +237-226719, +237-206084 FAX

CANADA

. BG Wendy Clay, Canadian Air Force, Dept of Defense, DHPP/Surgeon General, NDHQ Ottawa, +613-9920431, +613-9968336 FAX
. Maj. Rudolf Nowak, M.D., DHPP/Surgeon General, Dept of National Defence, Ottawa, K1A OK2, +613-9955205, +613-9968336 FAX

CENTRAL AFRICA

. Elie Kom, Medicine Capitaine, Republique Centrafricaise, Forces Armées Centrafricaise, BP 430, +257-010813,

CHILE

. Brig. Gen. Jorge Pérez Rifo, Fuerza Aerea de Chile, Dirección de Sanidad, Santiago, +562-6991226, +562-6965190 FAX

CHINA

. Wang Zheng-Guo, M.D., Editor-in-Chief, Chinese J. Trauma, Professor, Military Surgery, Dept 4, Research Institute of Surgery, Daping, Chongqing 630042, +86-811891, ext 424, +86-811813306 FAX
. Dr. Qi Xiaoqiu, Deputy Director, Department of Epidemic Prevention, c/o Division of Int'l Organizations, Ministry of Public Health, +861-4014332/861-5322567 FAX

CONGO

. Peter O. Fasan, M.D. GPA Programme Manager, World Health Organization, Region Office for Africa, P.O. Box 6, Brazzaville, +242-833861, +242-831879 FAX
. Docteur Pierre M'Pele, Directeur, Programme Natíonal de Lutte contre le SIDA, Boite Postale 1186, Brazzaville, +242-825412/836199

COTE D'IVOIRE

. Emmanuel Djakoure, M.D., Ministere Defense, Direction Du Service De Sante Des Armées, BP V11 Abidjan, +225-221289, +225-224028 FAX
. Felix Lorougnon, M.D., Commandant, Head, STD Programs Coordinating, Programme National SIDA, 04 BP 2113 Abidjan, +225-246796/243013, +225-243119 FAX
. Sibili Yelibi, M.D., M.P.H., HIV/AIDS Advisor, USAID, c/o American Embassy, 01BP 1712 Abidjan, +225-41-4528, +225-41-3544 FAX

CROATIA

. Petar Gotovac, M.D., Executive Committee, International Tourist Health Association, Zagreb Institude of Public Health, 4100 Zagrep/Croatia, Mirogojska 16, +38-41-272888, +38-41-272877 FAX

DENMARK

. Henrik Trykker, M.D., Technical Adviser, Ministry of Foreign Affairs, Danish International Development Assistance, 2 Asiatisk Plads, DK-1448 Copehagen K, +45-33-920000
. Torben Ishøy, M.D., Danish Armed Forces Health Services, Jaefersborg Kaserne, Postbox 149, Jaegersborg Allé 150, DK-2820 Gentofte, +45-31681655, +45-39760465 FAX

ETHIOPIA

. Cpt Abraham Yodit, M.D., Medical Director, Central Command Hospital, Defence Ministry, P.O. Box 30, Addis Ababa, +251-1112708, +251-1613714

FIJI

. Nemani Seru, Manager, Fiji National AIDS Programme, Suva, +679-312500, +679-301718 FAX

FRANCE

. Med Général Blin, Direction Service Santé des Armées, Hôtel des Invalides, Paris, +331-75007
. Colonel Dominique Jaubert, M.D., Médecin en Chief, Internal Medicine & Hematology Dept, Armed Forces Training Hospital, HIA Ste Anne, F83800 Toulon Naval, +33-94- 099208, +33-94-099232 FAX
. P.Dr. Joussemet, Chef du Service, Centre Transfusion Sanguines des Armées, 1 Rue R. Batany, 92141 Clamart, +161-464-52104, +161-463-88287 FAX

GERMANY

. Rita Appenzeller, Society for Applied Psychology, Ludwigstr 21, Wurzburg 97070, +49-93118387, +49-931571955 FAX
. Dr. Med. Heinz Bergmann, Surgeon Captain Navy, Zentrales Institut des Sanitatsdientstes der Bundeswehr, Viktoriastrabe 11-13, BW 442 D-5400 Koblenz, +49-261-4006945
. Hartmut D. Buchow, M.D., M.P.H., Division of Medical Research, AIDS/New Infectious Diseases, Ministry for Health, Koblenzer Strasse 63-65, 5300 Bonn 2, +49-228-941-3241, +49-228-941-4932 FAX
. Med Gunter Desch, M.D., Generaloberstab, Inspekteur des Sanitats und Gesundheitswesens, Bundesministerium der Verteidigung, Postfach 1328, 5300 Bonn 1, +49-228126340, +49-228129177 FAX
. Dr. B. Hauroder-Philippczyk, Electronermikroskopie, Federal Army of Germany, 53121 Koblenz
. Dr. Med. Roese, Ministry of Defence, In San I1, Professional Services and Medical Care, Post Box 1328, 53003 Bonn, +49-228-726353, +49-228-726689 FAX
. Lt Col Wolfgang Schardt, Deputy Branch Chief, Federal Ministry of Defence, In San I1, Federal Armed Forces, Post Box 1328, D-53003 Bonn, +49-228126233, +49-228126689 FAX
. Mike Storck, MC, Navy Regional Medical Command Easi, German Armed Force, Warnow - Barracks, Pressentin Str.33, D-18147 Rostock, +49-381-323127, +49-381-323098 FAX

GHANA

. Dr. E. Appiah Denkyira, M.D., c/o Dr. Phyllis Antwi, Manager, National AIDS Control Program, Ministry of Health, M44 Accra

GREECE

. Colonel Tegos Constantinos, Director, Veterans Hospital, Athens, Assoc. Prof., Dept of Internal Medicine, 24 Chiou Street, Cholargos 15562, Athens, +30-1-6514465, +30-1-6426940 FAX (also voice)
. MG Polymenakos Venetsanos, M.D., Hellenic National Defence General Staff, Patision 156, Athens 1257, +30-1-8671614, +30-16456282 FAX (c/o American Embassy)

HONDURAS

. Colonel Rolando Machado V, M.D., Director, Fuerzas Armadas de Honduras, Dirección De Sanidad Militar, El Ocotal F.M., Honduras, C.A., + 504-333291, +504 336986 FAX
. Colonel Francisco Reyes Mayes, M.D., Jefe Del Departamento de Administración de Personal (C-1), Fuerzas Armadas de Honduras Direccion de Sanidad Militar, Estado Mayor Conjunto, Honduras, C.A., + 504-333291, +504 336986 FAX

HUNGARY

. General Major Svéd László, M.D., Chief Medical Services, Hungarian Army, 1885 Budapest, P.O. Box 25, +36-11297812, +36-11491387 FAX

INDIA

. Robert A. Glick, Programme Officer, Regional Project on HIV/AIDS, 55 Lodi Estate, P.O. Box 3059, New Delhi-110003, +91-11-4632339/4632602, +91-11-4627612/0481 FAX
. Bhawani Shanker Kusun, Secretary, Gran Bharati Samitii, Jaipur, +91-141-565905, +91-11-4627612 FAX (c/o Mr. Dessau)

INDONESIA

. Col. Damanhuri Rosadi, M.D., M.P.H., Head, Subdirectorate, Office of the Director, Health Services, Dept of Defense and Security, JL Medan Merdeka Barat 13-14, Jakarta 10110, +62-21-362535, +62-21-4244507 FAX c/o NAMRU-2
. H. Soewarso, D.A., Air First Marshall Director, Specialist-Aviation Medical, Dept of Defence and Security, Directorate of Health, Merdeka Barat 13-14, Jakarta 10110, +62-21-8097382, +62-21-362535

ITALY

. MAJ Roberto Biselli, M.D., D.A.S.R.S. Rep. Medicina, Italian Air Force, Seroporto Pratica di Mare, 00040 Pomezla (RM), +396-910-8119, +396-916-01079 FAX
. Brig. Gen. Raffaele D'Amelio, M.D., Capo Ufficio Direttore Generale Sanitá, Ministero della Diresa, Direzione, Generale della Sanita' Militaire, Via Stefano Rotondo 4, 00184 Roma, +39-6-72209940, +39-6-77204934 FAX

JAPAN

. Fujio Kumagai, Director General for Health and Medical Affairs, Japan Defense Agency, 9-7-45 Akasaka, Minato-KU, +33-4084402
. Yasushi Mochizuki, M.D., Ph.D., M.P.H., Health and Medical Division, Educational and Training Bureau, Japan Defence Agency, 9-7-4J Akasaka, Minato-Ku, Tokyo 184, +3-34085211, ext 2071, +3-37461413 FAX

JORDAN

. MG Yousef Goussous, Director, Royal Medical Services, Senior Cardiac Consultant, Queen Alia Heart Institute-KHMC, Clinical Professor, Cardiology, Jordan University of Science & Technology, +962-815572, +962-849896 FAX

KENYA

. Major Josiah Nyaga Gakuru, M.D., Forces Memorial Hospital, Dept of Defence, P.O. Box 19522, c/o USAMRU, MOI Avenue/Haile Selassie Avenue, Nairobi, +254-2-810101, ext 5440, +254-2714608 FAX (c/o USAMRU-Kenya)
. Joan LaRosa, M.P.H., Health and Population Officer, REDSO/ESA, USAID, P.O. Box 30261, Nairobi, +254-2-331160
. Dan Wendo Ong'or, M.D., MBBS, M.P.H., Public Health Specialist, Epidemiologist and Medical Practitioner, Consulting Office, East View Clinic, P.O. Box 1261, Kibos Road, Kondele, +25-4-43447
. Godfrey Sikipa, M.D., Africa Regional Office, AIDSCAP/Family Health International, The Chancery, 2nd floor, Valley Road, P.O. Box 38835, Nairobi, +254-2-713913, +254-2-726130 FAX

LATVIA

. CPT Janis Micans, M.D., Chief, Medical Logistics Services, Latvian National Guard, 34 Ernestines Iela, Riga, +612113, +615650

LESOTHO

. Ellen Scout, B.A., Educator, AIDS Education Unit, Christian Council of Lesotho, P.O. Box 547 Maseru, +266-31-3639,

MEXICO

. Lt Col Oscar del Angel Guevara, Hematology and Hemotherapy Chief, Hospital Central Militar Sria Def Nal, Blvd. M. Avila Camacho S/N, Lomas de Sotelo, Mexico D.F. C.P. 11200, +525-557-3100, ext. 1520, +525-557-9743
. Juan Jacobo Hernández, Colectivo Sol General Coordinator, Colectivo Sol, Hidalgo #11, Col Pueblo Quieto, Tlalpan C.P. 14040 México D.F., +525 6666849, +525 6067216 FAX
. Brigadier General Surgeon José Antonio Ruiz Moreno, M.D., Zacatecas 44-Cons. 404, Col. Roma, A.P. 35-547, Mexico City 11694, +525-5841037, +525-5421330/2550095 FAX
. Leobardo Ruiz, M.D., Surgeon General, Secretarfa de la Defensa Nacional, Campo Militar 1-J Edificio Z 3er Nivel, 1500 Mexico, D.F., +011-5255573301, +011-5255572137 FAX
. Lt. Col. Jose Antonio Frias Salcedo, Jefe de Infectologia y del Comite Infecciones Hospitalarias, Hospital Central Militar, Secretaria de la Defensa Nacional, Industria Militar, Torres Departamentales Edificio, A-Int. 301, Colonia Militar, Lomas de Sotelo, Mexico DF, +525-557-3100, ext 1493/+525-5893405, +525-5579743 FAX

MOROCCO

. Tarmidi Abdelaziz, M.D., Medecin-Capitaine, Service De Dermatologie, Hôpital Militaire Mohammed V, Rabat
. Colonel Major Draoui, Professor, Department of Urology, Hópital Militaire Mohammed V, Rabat, +212 7-721629
. Hachim Mohamed, M.D., Medecin Militaire, Department of Internal Medecine, Hôpital Militaire Mohammed V, Rabat, +212-7771212
. Col Slimane Nejmi, M.D., Chief, Preventive Medecine and Biology Deapartment, Hôpital Militaire Mohammed V, Rabat, +212-7-730574, +212-7-708572 FAX
. Méd. Commandant Omar Sedrati, Professor de Dermato-Vènèrologie, Service de Dermatologie, Hôpital Militaire Mohammed V, Rabat, +212-7-730088, +212-2-295327 FAX (c/o Prof. A. Bensilmane)
. Professor Abdelhak Sekkat, Military Hospital of Instruction, Hôpital Militaire Mohammed V, Rabat, +212-7-730088/7730285, +212-2-295327 FAX (c/o Prof. A. Bensilmane)
. Ahmed Zidouh, M.D., M.P.H., Ministry of Public Health, 14, Rue Al Kalsadi, Agdal, Rabat, +212-7-778665/25

NAMIBIA

. N. Shivute, MBCh.B., M.Sc, Primary Health Care Directorate, Minintry of Health, 10/B 13198, Windhoek, +203-2304, National AIDS Programme Manager

NETHERLANDS

. Hendrika Detmers, M.A., Director, National Committee on AIDS Control, Polderweg 92, 1093 KP Amsterdam, +31 206939444, +31 206927989 FAX
. Col. F. Nobbe, BW - Krkhs NLM, Department of International Medicine, BW (Z. San), 06 Esolsberg 40, D 89081 NLM, +73-11-1212010
. M. van Ormondt, Plv Inspector, Ministerie van Defensic, Kalvermarkt 28, Postbus 20701, 2500 ES 'The Hague, +31-703187906, +31-703187701 FAX

NIGERIA

. Pearl Nwashili, Programme Director, STOPAIDS, 95 Suite ABC, Tafawa Balewa, 5052 MM Airport, Lagos, +234 2635219 (Voice/Fax)

NORWAY

. Bjorn Peter Berdal, M.D., Ph.D, Director, Microbiological Laboratory, Norwegian Defence Health Services, Joint Medical Staff, Geitmyrsveien 75, 0462 Oslo, +47-22-403366, +47-22-381158 FAX
. Lt. Col. Dr. Dommerud, Forsvarets Sanitet, IIQ Defence Command Norway, Joint Medical Services, Oslo Mil/Huseby, 0116 Oslo, +47-22-497052, +47-22-497335 FAX

PAKISTAN

. Brig. Amir Hussain Khan, MBBS, MCPS, FCPS, Armed Forces Institute of Pathology, Rawalpindi, +92-56132102, +92-56134086 (Res)

PERU

. Cmdr Rafael Elgegren Reategui, M.D., Advisor, Peruvian Navy Surgeon General Office, Direccion de Sanidad de la Marina, Marina de Guerra del Peru, Av. Salaverry Cuadra 27, Lima 11, +51-14-635903

PHILIPPINES

. Teresita Marie P. Bagasao, M.A., Exec Director/Secretariate, Kabalikat ng Pamilyang Pilipino Foundation, Inc., Asia Pacific Council of AIDS Service Org., Unit 104, First Midland Condo., Gamboa Street, Ligspi Village, Mahati, Metro, Manila, +632-8130478/9312688, +632-9311544/8128425 FAX
. Alberto I. Gabriel, M.D., Chief, Infectious Disease Service, Department of Medicine, Armed Forces of the Philippines, Medical Center, V. Luna Road, Camp Gen. E. Aguinaldo, Quezon City, +632-9211801, +632-7329063/+632-9211753, +632-7329063 FAX

PORTUGAL

. Manuel José Nobre Pires De Carvalho, Escola Do Sercico de Saude Militar, Rua Infaubra 16 - 4130, Lisboa
. Major Antonio Manuel Silva Graca, Chief, Infectious Diseases Department, Military Hospital, RVA Dr. Rafael Duswe, 6-4°E29, 1500 Lisboa, +351-1-3644152, +351-1-7782651 FAX
. Rear Admiral Zuis Borges De Sousa, M.D., Director, Naval Health Service, Edificio Da Marinha, Praea Do Comercio, 1100 Lisboa, +351-13463685

REPUBLIC OF KOREA

. Col. Myung Kyu Choi, M.D., Ph.D., Commander, Armed Forces Hospital, Teajon, Republic of Korea Army, ROKAF, HQ Hospital, Box 37, 800 Nam Li, Doo Ma Myun, Non San Gun, Choog Nam, +8-22-425501750/42-5501750, (c/o USAMRU-ROK)

REPUBLIC OF SOUTH AFRICA

. Montaunu Enea, Chief Coordinator, Township AIDS Community Project, NGO, P.O. Box 4168 Johannesburg, +27-11-9821016/1027, +27-11-9825621 FAX
. Alan W. Whiteside, Senior Research Fellow, University of Natal, Economic Research Unit, King George V Avenue, Durban 4001, +31-2602590/2587, 620177SA Telex

RUSSIA

. Col. Yuri Lobzin, D.MSc., Head, Dept of Infectious Diseases and AIDS, Military Medicine Academy, Lebedeva Street, Building 6, St. Petersburg, 194175 +812-5421330/1583, +7095-2302634 FAX
. Lt. Konstantin Zhdanov, M.D., Department of Infectious Diseases, Medico-Military Academy, Lebedev Street, Building 6, Saint Petersburg, +812-5421583

SENEGAL

. Alpha Boubacar Diallo, Chief, OPS Project RAF/91/004, Technical Advisor, United Nation Development Programme, BP 154 Daker, +221-234832, +221-234834 FAX
. Gary Engelberg, Africa Consultants International, Baobab Training and Resource Center, 509 Sicap Baobabs, BP 5270, Dakar, +221-253637, +221-240741 FAX
. Lt. Colonel Souleymane Mboup, Pharm.D., Professor, Faculté de Medecine and Pharmacie, University of Dakar, B.P. 7318, Dakar, +221-216420, +221-225919, +221-216442 FAX
. El Hadj Amadou Sy, Environnement et Developpement du Tiers-Monde, 4 Rue Kleber, BP 3370, Dakar, +221-229695

SLOVAKIA

. MuDr Václav Hradec, CSc., Primár Chirurgického Oddelenia, Vojenská Nemocnica SNP, 03401 Ružomberok, Bratislavia, +848-4142, +845-3303 (Res)
. Jan Vesecky, Generální Štáb ACR, Odbor vojenskeho zdravotnictvi

SWITZERLAND

. Manuel Carballo, M.D. Health Promotion and Prevention, World Health Organization, 1211 Geneva 27, Geneva, +41-22-791211, +41-22-7910746 FAX
. David L. Heymann, M.D., Chief, Research Global Programme on AIDS, World Health Organization, 1211 Geneva 27, +41-22-7914464, +41-22-7910317 FAX
. Lars O. Kallings, M.D., Ph.D., Adviser, Policy and Scientific Affairs, Global Programme on AIDS, WHO, 20 Avenue Appia, CH-1211 Geneva 27, +41-22-7914749/2111, +41-22-7910107 FAX

SWITZERLAND continued

. Stuart J. Kingma, M.D., Medical Officer, Planning and Policy Coordination, Global Programme on AIDS, World Health Organization, 1211 Geneva 27, +41-22-7914671, +41-22-7910107 FAX, Email: kingmas@who.ch
. Michael Merson, M.D., Director, Global Programme on AIDS, World Health Organization, 1211 Geneva-27, +41-22-7914660, +41-22-7910746 FAX
. Colonel Jacques Piguet, M.D., Deputy Surgeon General, Federal Military Department, Medical Corps Office, BASAN, Kasernenstr 7, 3003 Bern, +41-31-3292838, +41-31-3242771 FAX
. Tina Wiseman, NGO Liaison Officer, Global Programme on AIDS, World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, +41-22-7914655/7912111, +41-22-7910746 FAX
. Faustin Yao, Ph.D., Scientist, Global Programme on AIDS, World Health Organization, 20 Avenue Appia, CH 1211 Geneva 27, +41-22-7914572, +41-22-7910746 FAX

TANZANIA

. Rose Mapunda, R.N., Regional AIDS Control Coordinator, Health Dept, DAR City Council, P.O. Box 9084 Dar Es Salaam, +255-23551
. Callixte Twagirayezu, M.D., Department of Poediatrics, Bukoba Hospital, Medecins Du Monde, P.O. Box 1603, Bukoba, +255-66-20055, +255-66-21000 FAX

THAILAND

. Major General Pricha Singharaj, M.D., M.P.H., Director General, Armed Forces Research Institute of Medical Sciences, 315/6 Rajvithi Road, Bangkok 10400, +662-2457426, +662-2476232 FAX

TOGO

. Kpante Bassabi, M.D., Commandant, Forces Armées Togo/Oises (FAT), BP 365 Lome, +21-28-9192

TUNISA

. Mevr Plovie-Corthals, Dolgelly Walk 6, 41179 Monchen-Gladbach

TURKEY

. Dr Med Colonel Nurverdi Paktin, Dr.M.D., Head, Health Dept, Ministry of Defence, Ankara, +90-4-4181562, +90-41-84737 FAX

UGANDA

. Dr. Amans Lukanga-Ndawula, FRCS, (Ed), Chief of Medical Services, National Resistance Army, General Headquarters, P.O. Box 7069, Kampala, U+256-41-220760, +256-41-220712 FAX
. Ben Mbonye, MBChB, FRCS, MChOth, Secretary of Defence, Ministry of Defence, Box 7069, Kampala, +256-41-259673, +256-41-245911 FAX
. Dr. Peter N. Mugyenyi, MBChB, MRCP, DCH, Director of Research (HIV/AIDS), Joint Clinical Research Centre, P.O. Box 10005, Kampala, +256-41-270622, +256-41-242632 FAX
. Ezra Muhumuza, MBChB, M.P.H., Manager, AIDS Control Programme, Mbuya Military Hospital, P.O. Box 7069, Kampala, +256-41-220760, +256-41-220712 FAX
. Major Dr. Ambrose Musinguzi, MB.CH.B., Director of Public Health, National Resistance Army, P.O. Box 7069, Kampala, +256-41-220760, +256-41-220712 FAX
. Hon Manuel Pinto, Director General, Uganda AIDS Commission, Plot 28/30 Bombo Road, P.O. Box 10779, Kampala, +256-41-258538, +256-41-258173 FAX
. Sam Tumwesigire, MBCHB, M. Med, Project Manager, NRA HIV/AIDS Prevention Project, World Learning, Inc., Colline House, 4 Pilkington Road, P.O. Box 9007, Kampala, +256-41-233237/242429, +256-41-231743 FAX, Email:WLI@MUKLA.GA.APC.ORG

UKRAINE

. Col Anatolly G. Lurin, Central Military and Medical Dept, 28B Degtiarovska Street, Defence Ministry of Ukraine, Kiev, +44-2746283

UNITED KINGDOM

. Col. Christopher John Box, MBBS, Occupational Medicine, Defence Medical Services Directorate, First Avenue House, Room 709, High Holborn, London WCIV 6HE, +44-71-4305459
. Cpt. Ian P. Campbell, M.D., Medical Advisor - Salvation Army International Headquarters, P.O. Box 249, 101 Queene Victoria Street, London EC4P4EP, +44-71-2365222, +44-71-2364981 FAX
. Admiral Anthony Revell, MB, ChB, FRCA, Surgeon General, Lacon House, Room 105, Theobalds Road, London WCIX 8RY, +44-71-3055418, +44-705-588296 (Res), +44-71-3055468 FAX
. Douglas Webb, Ph.D. (consulting), Department of Geography, Royal Holloway College, University of London, London TW20 OEX, Egham, Surrey, +44-7-84443877, +44-7-84472836 FAX
. Rex Winsbury, M.A., Publisher, AIDS Analysis LTD, 45 Montpelier Grove, London NW5 2XG, +44-714859383, +44-714859383 FAX

URUGUAY

. Walter Meerhoff Behrens, M.D., Professor Agregado De Oftalmologia de la Facultad de Medicina, Canelones 1228, +598-322-901037/920232, +598-2621520 (Res)
. Col. Médico Nivea Garcia De Meerhoff, Sub-Directora Tecnia, Dirección National de Sanidad FF.AA., Avda. B De Octubre 3050, Montevideo, +598-2474409, +598-2621520 (res), +598-2474406 FAX

USA

. Ltc Judith Austin, M.A., Deputy Chief for Future Issues-Strategic Planning, HQ Air Force/XOXP, 1480 Air Force Pentagon, Washington, DC 20330-1480, +703-6973717, +703-6951050 FAX
. Col R. Neal Boswell, M.D., Deputy Director, MMCARR, Director, Laboratory Science, Division of Retrovirology, Walter Reed Army Institute of Research, 1600 East Gude Drive, Rockville, MD 20850, +301-2179410, 301-309-8346 FAX
. David Brandling-Bennett, M.D., Director, Division of Communicable Disease Prevention and Control, Pan American Health Organization, 525 23rd Street NW, Washington, DC 20037, +202-8614353, +202-8613143 FAX.
. COL Donald S. Burke, M.D., Director, MMCARR, Director, Division of Retrovirology, Walter Reed Army Institute of Research, 1600 East Gude Drive, Rockville, MD 20850, +301-2179410, +301-309-8346 FAX
. David Burrelli, Ph.D., Specialist in National Defense, Congressional Research Service, Library of Congress, CRS-F, 101 Independence Avenue, SE, Washington, DC 20540, +202-707-8033, +202-707-7639
. Paul Delay, M.D. U.S.A.I.D., AIDS Program, 1601 North Kent Street, 12th Floor, Arlington, VA 22209, +703-8774616
. Melvin Foote, Executive Director, Constituency for Africa, 1030 15th Street NW, Suite 340, Washington, D.C. 20005 +202-371-0588, +202-371-9017 FAX
. Dr. Gregory D. Foster, D.P.A., J. Carlton Ward Distinguished Professor, Industrial College of the Armed Forces, National Defense University, Washington, DC 20319, +202-475-0669, +202-475-0717 FAX
. Helene D. Gayle, M.D., M.P.H., Associate Director, Center for Disease Control, Hubert Humphrey Building, Room 714-B, 200 Independence Avenue SW, Washington, DC 20201, +202 6908598
. Jacob Gayle, M.D., Chief, HIV/AIDS Division, USAID, Office of Health, Res. & Dev./H/AIDS, SA-18, Suite 1214, Dept of State, Washington DC 20523, +703-8754494, +703-8754686 FAX
. Sven Groennings, Ph.D., 1104 Roberta Court, McLean VA, +703-3566030
. Capt Nancy A. Hazleton, M.P.H., International Health Officer, Office of International Health, 5600 Fishers Lane, Room 1874, Rockville, MD 20857, US Public Health Service, 5600 Fishers Lane, Rockville, MD 20857, +301-443-4010, +301-443-4549 FAX, Email: NHAZLETO@OASH.SSW.DHHS.GOV
. Robert Houston, International Relations Officer, U.S. Department of State, Bureau of Population, Refugees and Migration, 1281 SA-1, Department of State, Washington, DC 20522, +202-663-1713, +202-663-1061 FAX
. Peter R. Lamptey, M.D., Dr.P.H., Vice President, AIDS Programs, Family Health International, 2101 Wilson Boulevard, Suite 700, Arlington, VA 22201, +703-5169779, +703-5169781 FAX
. John Lowe, President, Henry M. Jackson Foundation for the Advancement of Military Medicine, 1401 Rockville Pike, Rockville, MD 20854, +301 2941202, +301 7387082 FAX
. William H. Lyerly, Jr., M.P.H., Sr. HIV/AIDS Advisor, USAID, AFR/ARTS/HHR, Rm 2744, Department of State, Washington DC 20523, +202-6476543, +202-6472993 FAX, Email: WLYERLY@USAID.GOV
. Julius Magembe, BSC, First Secretary, Embassy of Uganda, 5909 16th Street NW, Washington, DC, +202-726-7100, +202-726-1727 FAX
. Sandra Mendyk, Regional Affairs Officer, Bureau of African Affairs, AF/RA, Room 5232, Main State, Department of State, Washington, DC 20530, 202-647-5803
. Norman Miller, Ph.D., Editor-in-Chief, AIDS & Society, Professor, Dartmouth Medical School, 4 West Wheelock Street, Hanover, NH 03755, +802-6495296, +802-6492331 FAX, 4930372 TELEX
. Roscoe Moore, D.V.M., Ph.D., D.Sc., Associate Director, Office of the Assistant Secretary for Health, Department of Health and Human Services, 5600 Fishers Lane, Rm 18-87, Rockville MD 20857, +301-443-1774, +301-443-6288 FAX
. COL Eliot J. Pearlman, M.D., Command Surgeon, USMEPCOM, 2500 Green Bay Road, North Chicago, IL 60064-3094, +708 6883820, +708 6882453 FAX
. Peter L. Perine, M.D., M.P.H., Professor of Epidemiology, Center for AIDS and STD, Uniformed Services University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, MD 20814, +301-2953730

USA continued

- Elizabeth Preble, M.P.H., Director, Technical Support, AIDSCAP/Family Health International, 2101 Wilson Boulevard, Arlington, VA 22201, +703-516-9779, +703-516-9781 FAX, Email: S=EPREBLE % FHI @MCIMAIL.COM
- Elizabeth Reid, Director, HIV and Development Programme, United Nations Development Programme, 304 East 45th Street, New York, NY 10017, +212-906-6978, +212-906-6336 FAX, Email: Elizabeth.Reid@UNDP.ORL
- Mathew W. Roberts, Ph.D., Policy Officer, AIDS Control and Prevention Project, Family Health International, 2101 Wilson Boulevard, Ste 700, Arlington VA 22201, +703-5169779, +703-5169781 FAX
- Alex Ross, M.S.P.H., Technical Advisor for Health Policy, USAID, Bureau for Africa/ARTS/HHR, 1111 North 19th Street, Suite 300, Rosslyn, VA 22209, +703-2354453, +703-2354466 FAX
- John B.K. Rutayuga, Ph.D., Executive Director, Co-Director, Ukimwi Orphans Assistance/Center for Natural and Traditional Medicines, P.O. Box 29074, Washington, DC 20009, +202-234-9632, +202-332-2132 FAX
- CAPT William Tauber, M.D., Head, Central HIV Program, U.S. Navy, National Naval Medical Center, Box 132, 8901 Wisconsin Avenue, Bethesda, MD 20852, +301-295-6590, +301-295-2831 FAX
- Basil P. Vareldzis, M.D., M.P.H., Sr. Technical Advisor for Tuberculosis/HIV, Office of Health, USAID, R&D/H/AIDS, SA-18, Ste 1200, Washington DC 20523-1817, +703-8754494/4628, +703-8754686 FAX
- James L. Woods, B.A., M.A., Vice President, Cohen and Woods International, 1555 Wilson Boulevard, Suite 300, Arlington, VA, 22209, +703-875-8714, +703-243-3177 FAX
- Rodger Yeager, Ph.D., Prof., Political Science, Director, International Studies, West Virginia Univ., Int'l Studies Program, PO Box 6317, Morgantown WV 26506, +304-2932595, +304-2938644 FAX, Email: RYEAGER@WVNVM.WVNET.EDU
- Fernando Zacarías, M.D., Dr.P.H., Coordinator, Regional Program AIDS/STD, Division of Communicable Disease Prevention and Control, Pan American Health Organization, 525 23rd Street NW, Washington, DC 20037, +202-8614354, +202-8616089 FAX

VENEZUELA

- Dra Beatriz Ganráler Del Castillo, c/o Commander, SMILGP-Venezuela, Unit 4980, APO AA 34037

ZAMBIA

- Brig. Gen. Brian Chituwo, MBChB, FRCS (Ed), Commandant, Dept of Surgery, Ministry of Defence, Mania Soko Military Hospital, P.O. Box 320091, Woodlands Lusaka, +260-262501, +260-263883 FAX

ZIMBAWE

- Peter P. Chibatamoto, Medical Research Officer, Blair Research Institute, Ministry of Health, Box 8105 Causeway, Harare, +263-792747
- J. P. Fraser-Mackenzie, Commercial Farmers Union, Leopold Takawira St, Harare, +263-791881

NEW MEMBERS

The Alliance invites anyone concerned with HIV and AIDS in civil-military settings to join the Alliance, receive the newsletter, and to contribute brief news, research, or general interest items. Please contact us with your name, institution, address, and telephone and fax numbers at the following address:

Civil-Military Alliance to Combat HIV and AIDS
c/o AIDS and Society
4 West Wheelock Street
Hanover NH, 03755 USA
FAX: USA 802 6492331

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HIV will cause development ranking to drop

NEW DELHI. In Asia, the AIDS epidemic is likely to have a much more damaging effect on overall development than on economic growth alone, according to new research from the UNDP (United Nations Development Programme).

The research suggests that the growth in incomes in countries severely affected by the epidemic — such as India, Myanmar and Thailand — will be slightly reduced. But those countries will lose years of 'human development' as measured by the UN's Human Development Index (HDI). The HDI ranks the countries of the world according to four indicators: life expectancy at birth, adult literacy, school enrolment, and real gdp *per capita*. AIDS is likely to affect all of these, with the result that many countries' HDI will not grow as fast as expected (*see table 1*).

TABLE 1:

HUMAN DEVELOPMENT INDEX			
	1992	2005 (no AIDS)	2005 (AIDS)
INDIA	0.382	0.488	0.482
INDONESIA	0.586	0.693	0.692
MYANMAR	0.406	0.514	0.475
PHILIPPINES	0.621	0.762	0.76
THAILAND	0.798	0.864	0.82

Source: UNDP

The research calculated what a country's HDI could expect to be in 2005 if no new AIDS cases occurred after 1993 ('no AIDS' column), and if the epidemic continued at present rates. In addition, it calculated how many years of 'human development' would be lost if each country eventually had an epidemic on the scale of that in Myanmar (*see table 2*).

As many countries are only in the very earliest stage of the epidemic, a significant impact will not become apparent in the next decade.

'In each case, the countries' HDI will be lower in the "with AIDS" scenario. There are not many things in the world today which we would expect to lower countries' HDI,' Peter Godwin, chief of the UNDP regional HIV project told the third international conference on AIDS in Asia in September.

'While it is commonly accepted that the HIV/AIDS epidemic is a

(Continued on page 2)

New vaccine hopes from German-Chinese research

REGENSBURG, Germany. A revolutionary new approach to making vaccines, which involves stimulating the body's natural immune response, may hold the key to the development of an HIV vaccine. The first human trial of an HIV vaccine made in this way is planned for late next year, following successful tests in monkeys.

Rather than stimulating antibodies, as most vaccines do, this new vaccine stimulates the production of T-cells, which scientists are increasingly coming to believe to be crucial to the development of an AIDS vaccine. Developed by German and Chinese scientists, the new vaccine is based on 'HIV-like' particles.

T-cells seek out and destroy infected cells and are part of the body's natural immune response to infection. Earlier this year, a group of sex-workers who seem to be immune to HIV were discovered in Gambia (*AIDS Analysis, passim*). Though the women had been repeatedly exposed to HIV, they had not become infected. All had high levels of T-cells.

'We have to take a lead from nature,' says Professor Hans Wolf of the Institute of Medicine and Microbiology and Hygiene in Regensburg, Germany. 'In addition to the Gambia group, people in the US who have been HIV-positive for many years and not yet developed AIDS also have high numbers of T-cells. The present vaccines don't work because they don't pay enough attention to T-cell response,' he said.

Last year, US researchers said they had encouraging results from monkey trials of a vaccine based on 'live' virus particles. Other scientists warned that such a vaccine was dangerous as there was no way of guaranteeing it would not cause AIDS.

The difference with HIV-like particles is that, because they have no nucleic acid, they cannot reproduce. Aside from the 'live' vaccine developed in the US, most other vaccines have concentrated on producing antibodies which attack a single strain of the HIV virus. The problem is that HIV can mutate and quickly becomes resistant.

The new 'HIV-like' vaccine is the result of a joint effort between the Regensburg Institute, the Institute of Virology in Beijing and the WHO. It will be tested in Yunnan province, China, which is believed to have one of the highest HIV rates in Asia. Just across the border, in Kachin state, some 84% of intravenous drug-users are HIV-positive. ■

● In this issue

HDI (continued from page 1):

problem with potentially serious consequences not only for national economic well-being but also for human development, and one that requires policy-makers' urgent attention' he said.

The UNDP research, carried out with the support of the Asian Development Bank, looked at countries — China, Indonesia, Korea, Myanmar, the Philippines, Sri Lanka and Thailand (*see AIDS Analysis Africa*, Vol. 1 [1&3]). Further research from Colombia University covering 60 countries suggests that improvements in HDI have been significantly less impressive in countries with severe epidemics.

The research also compared the impact of AIDS to the impact of malaria and tuberculosis. It found that none had a 'direct statistically significant effect on the HDI', though the rapid increase in TB-associated HIV is likely to change this picture.

Peter Godwin stressed, '...this work clearly showed the multi-dimensional nature of the HIV/AIDS epidemic. You cannot take one measure, such as economic growth, epidemiology or human rights, and hope to understand what the epidemic is doing to countries. We need a broader measure, like 'human development', which will help us realise the devastating nature of what is happening. This is why the HDI is a good tool for understanding things like the HIV epidemic,' he said.

❑ The Asian Development Bank referred to the threat AIDS posed to national economies at the Chaing Mai conference. Dr Myo Thant of the ADB emphasised the inequitable social and economic costs of the AIDS epidemic and said that AIDS was the 'enemy of Asian promise because it endangers development'. ■

TABLE 2:

LOSS OF HUMAN DEVELOPMENT (YRS)		
	With current projections	Myanmar scenario
INDIA	0.74	4.77
INDONESIA	0.1	4.75
MYANMAR	0.21	4.93
PHILIPPINES	0.25	5.26
THAILAND	8.71	7.69

Source: UNDP

'Rehabilitation' plans anger Thai women's groups

BANGKOK. Thailand's long awaited Prostitution Bill (*AIDS Analysis Asia*, Vol. 1 [3]) was passed by the house of representatives in September, but women's groups argue that it does not do enough for child prostitutes.

The new bill's harsh penalties for customers of child prostitutes, brothel-owners and parents have been welcomed. The old Prostitution Suppression Act of 1960 made provision for prosecuting clients, brothel-owners and pimps, but according to the Department of Public Welfare in Bangkok, was never enforced. Specifically, the new law stipulates for children under the age of 15 years:

- clients can be gaoled for 2-6 years, and fined 40,000 to 120,000 Baht ($1,600-$4,800).
- 'procurers, owners and caretakers' can be jailed for 1-5 years and fined 20,000 to 100,000 Baht.

If the child is over 15 years but younger than 18 years:

- the client can be gaoled for 1-3 years, or fined 20,000 to 60,000 Baht.
- the owners, etc. can be imprisoned for 3-15 years and fined 60,000 to 300,000 Baht.

But the bill has been criticised for its treatment of the children themselves. Siriporn Skobanek, general secretary of the Foundation for Women also says that the proposed 'rehabilitation centres' for child sex-workers will be prison-like. The children have no choice about whether they attend the centres and are not allowed to leave for two years.

'It is the de-criminalisation of women in the sex industry which is urgently required,' argues Siriporn, 'and the removal of any laws prosecuting them.' ■

The 'quiet' revolution makes itself heard in Bangladesh

FAMILY planning clinics are increasingly gaining acceptance in Bangladesh, one of the world's poorest and most densely populated countries. But condom use remains low, reports ***Roushan Zaman***

Health Minister Chowdhury Kamal Ibne Yusuf points out that despite poverty and the low rate of literacy, family planning programmes have madegreat headway in Bangladesh, defying all demographic theories.

He describes the headway as a 'quiet revolution' and attributes success to the government, the country's nearly 50,000 family planning fieldworkers — more than half female — and to non-governmental organisations. 'For a nation like Bangladesh there is no alternative to population control. If we can't curb the population growth, it will be disastrous,' he says.

In June the Bangladesh Demographic and Health Survey (BDHS), released a report based on interviews with over 9,500 married women aged between 10 years and 49 years. The survey indicated that the country's fertility rate — the average number of children born to a woman in her lifetime — declined from 6.3 births per woman in the early 1970s to 3.4 births in 1993-94.

The BDHS shows that the use of contraception has increased almost sixfold and that the idea of small families has become widely accepted. It adds that the use of contraceptives among married women increased from 8% in 1975 to 45% in 1995, and that 89% of couples now approve of family planning.

But the birth control pill accounts for 40% of all contraceptive use. Only 3% of women rely on condoms; a fact that may cause problem for AIDS prevention efforts. ■

Roushan Zaman is Editor of United News of Bangladesh, an independent news agency.

User-friendly guide involving the community

TRAINING MANUAL ON REPRODUCTIVE HEALTH AND HIV/AIDS FOR YOUTH AND WOMEN IN MYANMAR: A COMMUNITY-BASED APPROACH. Developed by Dr Werasit Sittitrau for UNICEF in collaboration with the Thai Red Cross Society.

DESIGNED to help community workers in rural Myanmar raise awareness of HIV/AIDS, this training manual covers all the associated issues such as care among youth and women. Each topic is approached in a practical and user-friendly manner. It focusses on the importance of involving the community, friends and family in all situations and covers almost every aspect of a person's personal life. 'The manual aims to promote not only knowledge and awareness... but also to motivate action, interaction and support among the community members,' explains the author.

It was designed by Dr. Werasit Sittitrau and is part of UNICEF's project for prevention and control of HIV/AIDS in Myanmar through promotion of reproductive health. The project is carried out with the Thai Red Cross.

The manual has been printed in English and two Myanmar languages. It was extensively tested before publication among youth and women to ensure the most accessible style and type of language was used. It deals with a variety of topics from peer group pressure to sexual education. It is presented in such a way that it could be used anywhere in the world, something that Dr Sittitrau originally intended.

The manual is divided into eight main lessons with many sub-divisions. The lessons include: happy and healthy living, which is essentially a sociological look at physical and mental development during human life; community-based counselling; friend-to-friend education, which looks at the positive and negative effects of peer group pressure and a section on making good decisions. Other chapters cover: reproductive health and birth spacing; HIV/AIDS; tuberculosis; family and community; family and community care or persons with HIV/AIDS.

Every lesson provides either basic medical background or positive psychological advice, with each message reinforced with cartoons which illustrate role-playing scenarios.

The training manual provides a rounded and understanding approach to HIV/AIDS, and deals with issues in a reassuring and accessible manner. For example, in a section dealing with what to do if someone you know has HIV/AIDS it says, 'People with HIV/AIDS, like those who are sick with other diseases, need your support.... Some other people might want to blame a person with HIV/AIDS for having the disease. You need to explain to people that anyone in this country can get HIV/AIDS. People with HIV/AIDS are still our fiends, our children, our brothers, our sisters, and our family members.' ■

Just a World Bank PR exercise?

GENDER ISSUES IN WORLD BANK LENDING, by Josette L. Murphy. A World Bank Operations Evaluation Study (1995).

THIS evaluation study traces the evolution of 'gender-awareness' at the World Bank. The Bank claims that it assesses projects to determine how they will impact on women before providing loans, but admits that its track record on gender has been less than ideal. Director-general Robert Picciotto claims 'after extended debate and experimentation, many of the prerequisites for a full integration of gender issues in Bank lending are now in place.'

But many observers, particularly those from NGOs, question whether there has been genuine change. Some believe this study is just a poor attempt at a public relations exercise. As one pointed out, 'the World Bank is ultimately only interested in how to most efficiently implement its economic policies, it is not particularly interested in advancing the women's movement.'

If there has been a change, this review does not give a clear indication of how it has come about. Nor does it provide many hard facts about what 'gender-sensitive' criteria new loans are subject to. As the author points out in the first few pages, 'Gender roles are determined by cultural and religious beliefs, so they vary across ethnic, income, or class groups, even within countries. Interventions that could entail a change are, by definition, sensitive. Yet such changes often occur spontaneously as economic and technological conditions evolve.'

Policy on gender issues affecting Bank lending is divided into two periods — reactive and proactive. In the reactive years between 1967-1985, gender issues were not deemed important enough to affect the Bank's overall lending policy. From 1986 on, a proactive stance was taken and gender issues were prioritised. But it was not until April 1994 that the Bank finalised it's policy.

Examples of 'gender-sensitive' projects are those which aim to keep girls in school or provide back-up assistance to female entrepreneurs and farmers.

One criticism levelled at the World Bank, indeed at all big institutions, is that a policy loses its cohesiveness as it is implemented. Approval from 'the top' may not necessarily persuade those putting the policy into practice that it is important or needs to succeed. This study recognises the problem and is itself an attempt to raise awareness of gender issues among its own staff.

Perhaps one reason the Bank is paying more attention to women is that it makes sound economic sense. Previous World Bank reports have pointed out that project efficiency increases proportionately to the number of women involved. ■

Conference calls for greater commitment

CHIANG MAI. The overwhelming message of the Third International Conference on AIDS in Asia was that governments need to take the epidemic far more seriously. Dr Peter Piot, executive director of UNAIDS, warned countries which currently have only a small epidemic that they should 'act before the need arises'. He said that a greater commitment was needed if prevention efforts were to overcome political, cultural and economic factors. 'A very mixed record on blood safety, particularly in this region, shows that even when excellent technology exists, logistic managerial and financial obligations frustrate the implementation,' he said.

His words were echoed by former Thai Prime Minister Anand Panyarachun, the first head-of-state to chair a national AIDS programme. 'Today, AIDS remains the most critical threat to the social and economic progress of the region.... The leaders of our countries are not taking AIDS seriously enough,' he said.

Meechai Viravaidhya, former secretary of Thailand's National AIDS Committee praised Mr Anand as 'perhaps the most enlightened politician in HIV/AIDS'. But he said the present government's attitude was one of 'indifference', pointing out that the National AIDS Committee has still not held its first meeting nor has AIDS been mentioned as part of national policy.

In contrast, Dr Piot had only praise for the host country. 'The ultimate burden [of the epidemic] will be greater elsewhere — in part because few countries have responded as actively to AIDS as our host country has,' he said. He also stressed that greater attention needed to be paid to women's needs, including those of sex-workers. 'Women traditionally have little or no say in decisions about sex, and certainly are not expected or encouraged to discuss these matters in the family. Even if they suspect they are at risk of HIV infection from their husband, what control do they have over the three prevention options: abstinence, fidelity, condom-use? How could they leave the marriage? ...HIV in pregnant women is often described as tragic. I feel that HIV in sex-workers is just as tragic — in fact it compounds their exploitation.' ■

PWAs have their say at last

Personal view of the conference by
Veena Lakhumalami

CHIANG Mai provided a beautiful backdrop for the Third International Conference on AIDS in Asia and Pacific. This city in the north of Thailand offered representatives an invaluable opportunity to share experiences and ideas. It brought together generalists, specialists, bureaucrats, donors and vulnerable communities in an effort to tackle jointly the fight against AIDS.

An interesting feature of the conference were the meetings which addressed the needs of people living with AIDS, a departure from previous conferences. These sessions were valuable, interesting and emotional, and provided a secure atmosphere to enable PWAs to be open about their status.

A representative from Uganda raised the important issue that attention needed to be paid not just to the needs of people 'infected' with AIDS, but also those 'affected' with AIDS.

Plea for 'balance' in Vancouver

At the concluding session, representatives from gay, lesbian and sex-worker communities strongly protested that sufficient time and scope was not given to their problems. They said they resented the fact that they are often blamed for the spread of the infection and complained that solutions to their difficulties are not considered adequately. All three made an urgent plea that the Vancouver conference in 1996 address this imbalance.

Participants had difficulty in deciding which session to attend as several interesting meetings were held simultaneously. Some of the scientific programmes had too many speakers and the organisers had not adequately screened the abstracts, which resulted in some very poor presentations. Considering the venue was in an Asian country, little attempt was made to provide suitable food for vegetarians!

More seriously, some participants raised eyebrows at the cost of organising such an event. However, friendships were made, bonds were strengthened, networking was established and, importantly, information was shared and gained. ■

UNAIDS likely to cut funding

THE new UNAIDS organisation — due to be operational by January 1 1996 — will be primarily an advisory body, a hint that current GPA funding to national AIDS control programmes will be cut.

UNAIDS executive-director Dr Peter Piot told the Chiang Mai conference, 'We will have three mutually reinforcing roles: policy development and research, technical support and advocacy.' This seems to mean that while UNAIDS will help countries mobilise resources, it will not provide any itself.

'First, UNAIDS will be a major source of the globally relevant policies and strategies that countries need for their expanded response. We won't be an ivory-tower think-tank. Constant feedback from the field will help us identify promising elements of what I like to call "international best practice" in the context of AIDS. Then, through technical support, we will help countries incorporate these policies, strategies and actions into their response,' said Dr Piot.

Logistically, it is still not clear how the organisation will work or how many staff it will have. 'Technical intercountry teams' will visit each region and a permanent staff member will be based in some countries. It is not yet clear what UNAIDS's operating budget will be, though Piot has requested $140m for the organisation's first two years of operation. ■

The current HIV/AIDS situation in Asia

COUNTRY	PRIMARY RISK BEHAVIOURS	REPORTED AIDS CASES	SAMPLING OF HIV SEROPREVALENCES AND YEAR OF STUDY	*CURRENT ASSESSMENT*
SOUTH KOREA	Heterosexual	**19**	0.1% of sex workers (1988) O.3 of hæmophiliacs (1985-1990)	*Increasing*
SINGAPORE	Homosexual/ Heterosexual	**75**	3.6% of homosexuals/bisexuals (1992) 0.5% of STD patients (1993)	*Increasing*
SRI LANKA	Homosexual/ Heterosexual	**37**	0.5% of sex workers in Colombo (1993)	*Increasing*
TAIWAN	Heterosexual/ IVDU	**48**	2.2% of homosexuals (1988) 0.3% of STD patients (1991) 0.4% of IVDUs (1988-1990)	*Increasing*
THAILAND	Heterosexual/ IVDU	**5,654**	1.8% of antenatal clinics (1993) 33% of IVDUs (1993) 29.8% of sex workers (1993) 8.7% of STD patients (1993)	*Rapidly increasing*
VIETNAM	Heterosexual/ IVDU	**107**	8.7% of IVDUs (1993)	*Early epidemic but increasing rapidly*
LAOS	Heterosexual	**14**	0.8% of blood donors (1993)	*Increasing*
MALAYSIA	Heterosexual/ IVDU	**107**	6.9% of IVDUs (1991) 1.4% of sex workers (1991)	*Early epidemic, potential for rapid increase*
MYANMAR	Heterosexual/ IVDU	**261**	0.3% of blood donors (1991) 1.0% of pregnant women (1990) 11% of sex workers (1991) 76.5% of IVDUs (1991)	*Increasing*
NEPAL	Heterosexual/ IVDU	**24**	0.8% of sex workers/STD patients (1993) 1.6% of IVDUs (1991)	*Increasing*
NORTH KOREA	Unknown	**0**	None available	*Unknown*
PAKISTAN	Heterosexual	**24**	4.4% of sexually active (1990) 0.8% of paid blood donors (1986)	*Increasing*
PHILIPPINES	Heterosexual/ Homosexual	**136**	0.1% of sex workers (1992) 0.3% of homosexuals (1988)	*Increasing*
BANGLADESH	Heterosexual	**1**	None available	*Unknown*
CAMBODIA	Heterosexual	**0**	0.8% of blood donors (1992) 9.2% of sex workers (1992) 4.2% of STD patients (1992)	*Rapidly increasing*
CHINA	Heterosexual/ IVDU	**36**	12.5% of IVDUs in Yunnan (1991)	*Increasing, especially in southern provinces*
HONG KONG	Homosexual/ Heterosexual	**99**	1.8% homo/bisexual Chinese (1989) 39.4% hæmophiliacs (1987)	*Increasing*
INDIA	Heterosexual/ IVDU	**713**	1.8% of IVDUs (1986-1991) 41.2% Bombay sex workers (1992) 1.4% pregnant women in Manipur (1992) 7.8% STD patients in Tamil Nadu (1991)	*Rapidly increasing*
INDONESIA	Homosexual/ Heterosexual	**49**	0.6% of transvestites (1989-1990) 0.1% of overseas workers (1988)	*Early epidemic, potential for rapid increase*
JAPAN	Homosexual/ Heterosexual	**713**	2% of homo/bisexuals (1988) 36.8% of hæmophiliacs (1985)	*Increasing*

This data was released by the World Health Organisation at the Chiang Mai conference

'Risk-taking' visitors from within Asia will raise HIV in Cambodia

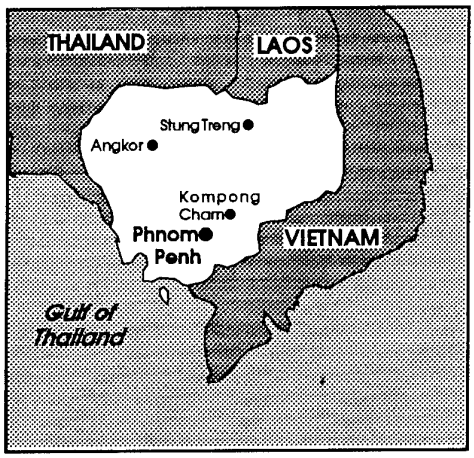
*Tourism has played an important role in the economic development of many countries, and could play a key role in Cambodia's recovery. But, **Tony Barnett** warns, unless the fledgling industry is handled carefully, it could facilitate the spread of HIV.*

IN Cambodia today, tourism is one possible route to increased income and, if the resulting income is spread widely, could contribute to improved living standards for an impoverished population. However, with the popularity of 'sex-tourism' and the increasing spread of HIV/AIDS in south-east Asia, such developments carry with them special risks.

Those planning the development of this sector — in any country — need to consider how they are going to prevent HIV-infection spreading from Cambodians to visitors and from visitors to Cambodians, and from those working in tourism to the wider population. In short — how to maximise economic returns while minimising opportunities for disease transmission.

Burgeoning of tourism

Tourism and travel is a vast and growing business. In 1987, it was estimated that the industry had world-wide sales of $2 trillion and employed 6.3% of the global workforce. It includes passenger-transport industries, hotels and accommodation, restaurants and other food and drink providers, recreational and cultural services, manufacture and sale of curios and provision of information.



It is by nature a highly reticulated sector with many links to other parts of the economy and society at local, regional, national and international levels. Indeed, it might be said that one of its main functions is to develop and expand communications networks — to facilitate the movement of people and thus inevitably also of disease.

The pattern of global tourism will change over the next decade. The European and American markets are likely to grow more slowly as the growth in disposable income slows. The number of tourists from Japan and the newly-industrialised countries of Asia will boom. Only one Japanese in ten travels abroad at present, compared to one European in two. Only 5% of Koreans and 2% of Thais travel for recreational purposes. But foreign travel is becoming increasingly popular, a trend which will result in a massive increase in demand for destinations — both globally and in the Asian region.

In 1994 Cambodia received 150,000 tourists and is expected to receive a further 225,000 this year. Currently, the country attracts many low-spending, mainly young, and undoubtedly adventurous 'backpackers'. However, there are signs that it is attracting increasing numbers of wealthier visitors — particularly from France and Japan — many of whom are interested in visiting the historical monument of Angkor Wat.

High-risk destination

It may be observed that a wish to visit Cambodia at all — a country only recently emerged from civil war — could indicate that the average tourist is either ignorant or a risk-taker. The latter possibility is important as it has obvious implications for other 'risky' behaviour.

The current security situation necessitates that most tourists are carefully shepherded and channelled by authorities, a point relevant to the possible introduction of HIV-control measures.

It seems likely that if the Cambodian tourist market expands, most of the new visitors will be Asian. This may mean that future holiday-makers will expect access to sex and gambling.

In 1993, 60% of travellers in the Asia Pacific region originated from within Asia, and the market seems to be growing. Asian tourism is more a high-volume industry than a high-value one, which presents special problems for Cambodia. It will have to compete with the Philippines and other countries which provide relatively low-cost, short-break holidays with an emphasis on sex and gambling.

Comparatively little is known about the progress of the HIV/AIDS epidemic in Cambodia. However, what information is available suggests that the infection is already well-established. Data from the Cambodian National AIDS Programme indicate seroprevalence rates as follows in 1994: 2.8% among a sample of blood donors, 11.4% among a sample of STD clinic attenders, 39.4% among commercial sex workers, 8.6% among TB patients. More than 700 HIV cases have been officially reported and it is estimated that some 6,000 people carry the virus.

Avoiding downstream costs

If India and Thailand offer any indication, it is probably correct to assume that the HIV/AIDS epidemic in Asia will be more similar to the epidemic in Africa than to the epidemic in western Europe and north America. This means that after an initial focus in certain population

In 1993, 60% of travellers in the Asia Pacific region originated from within Asia, and the market seems to be growing. Asian tourism is more a high-volume industry than a high-value one, which presents special problems for Cambodia.

groups—for example, IV drug users and commercial sex-workers — the disease will rapidly enter the general population.

The planners and instigators of tourist development must start to take HIV/AIDS seriously if the risk of a widespread epidemic is to be reduced. Careful identification of 'low-risk' tourist market sectors — for example, wealthy couples visiting historic sites rather than single men coming to gamble — might be one component of such a strategy. Other components could include: careful training and sensitisation of all Cambodians working in the tourist sector; training of commercial sex-workers in negotiating condom-use and easy and cheap availability of condoms in all tourist venues.

Ideally, HIV/AIDS information would be included in brochures distributed in the home countries of tourists they would be provided with information about HIV/AIDS in their own language on arrival, but travel companies are likely to resist such measures.

They should bear in mind that caution now may help to avoid increased spread of HIV-infection and thus will lead to long-term savings on costs associated with increased illness, death, labour shortages in agriculture (as the productive cohorts are lost to AIDS), and care of HIV/AIDS sufferers and their children.

The importance of the above measures and others is that if the benefits of tourism for national development are to be reaped, then the industry must be cultivated in such a way that the long-term costs of HIV/AIDS associated with tourism do not outweigh the short-term benefits of increased income. ■

Government apathy is potentially catastrophic World Bank warns

by Michael Porter

CAMBODIA is at the threshold of a major HIV epidemic, possibly catastrophic in both human and economic terms. Although the epidemiological data is thin and some recent results require review, it is increasingly evident that Cambodia is experiencing a rapid rise in the level of HIV prevalence. All areas of the country and different sectors of the community are affected.

The National Blood Transfusion Service (NBTS), largely run by the International Committee of the Red Cross, provides the only longitudinal data on HIV prevalence in Cambodia. HIV was first detected in 1991, among blood donors. At that time the prevalence rate was 0.075%. By 1994, the rate had risen to 2.8%.

However, it is not clear whether these figures are representative of the wider society. In theory, blood comes from voluntary donors. But there is some evidence that relatives who are asked to provide blood for sick family members purchase that blood from a specific group, some of whom may be HIV-positive. This issue will soon be investigated by the NBTS.

Small-scale HIV surveys have been conducted among commercial sex-workers (CSWs) and among those with sexually transmitted diseases (STDs). In Phnom Penh in 1992, 9.2% of CSWs and 4.5% of STD patients were found to be HIV-positive. A further study in November 1994 revealed that HIV-rates had risen dramatically among CSWs across the country. In Sihanoukville, 39.4% of CSWs were reported to be HIV-positive, while in Battambang and Banteay Mean Chey, the rate was over 60%. (Some experts have questioned the accuracy of results in Banteay Mean Chey, however). Meanwhile, in Phnom Penh the HIV-rate among STD patients had risen to 11.4% by late 1994.

Cambodia's response to the epidemic has been largely driven by external concern and support, particularly from the WHO, and the international NGO community. The World Bank has also become involved in recent efforts to tackle the epidemic. It is currently preparing an HIV/AIDS component to a proposed health project for the country. These efforts have been crucial in persuading the Government to acknowledge the seriousness of the AIDS issue, and prompted it to contribute some of its own resources.

A National AIDS Committee (NAC) was formed in 1992 to provide a multi-sectoral response to the epidemic. But, chaired by the Minister of Health, the NAC has not been particularly effective in mobilising the interest or commitment of other ministries. In 1994, the NAC changed its name to the Inter-ministerial Committee for AIDS-STD Prevention and Control, but little changed in practice.

However, there is some indication that senior members of government are at last becoming aware of the country's HIV problem. During a visit by Dr Michael Merson from the WHO in November 1994, Prince Norodom Ranariddh, one of the two co-Prime Ministers, agreed to chair the new AIDS committee.

This move should help to gain the attention of a broader constituency within the government. The following month provided another encouraging sign. On December 16, speakers at the closing ceremony of the annual National Health Conference in Phnom Penh pointed to policy failures at the NAC and the need for more openness in dealing with the AIDS issue.

Though AIDS is currently invisible it will soon become a threat to the country's social fabric. Much more still has to be done to prevent its rapid increase. ■

Michael Porter works at the World Bank in Washington

By virtue of their occupation, soldiers and sail

AIDS is a major background factor in the destabilisation of some regions and may well play a role in regional conflicts and disorder. Rwanda is a classic case — unquestionably, high levels of HIV and AIDS in the military ranks was a factor in the brutality and genocide.

Even when peace-keeping is the mission of militaries, HIV and AIDS are an issue. Some observers believe that since 1980, more UN peace-keeping troops have died of AIDS, or will die of AIDS soon, than have been killed in combat. With over 70,000 UN troops deployed on 18 different assignments, HIV and AIDS remains a major threat.

Peer pressure

Military personnel are among the most susceptible populations to HIV. They are generally young and sexually active, are often away from home and governed more by peer pressure than accustomed social taboo. They are imbued with feelings of invincibility and an inclination towards risk-taking, and are always surrounded by ready opportunities for casual sex.

National military forces, particularly those in developing countries, are being devastated by the epidemic. HIV-rates in some armies, particularly those in Africa, are over 45% of all military personnel. Officers in some flying units and armoured units are reported to be 100% positive.

The military has the responsibility to defend the nation and its interests against harmful forces or unwanted outside intervention. When the military is weakened as a result of a disease such as AIDS, and the national conscription pool from which it draws its troops becomes increasingly unhealthy, the defensive posture of a country is weakened.

Peace and security

Peace and security begins with economic stability and AIDS is a major threat to economic well-being. In both civil and military spheres, AIDS is a 'hollowing out' process, striking mainly at the 20-40 age-group and often taking the more senior officers and high-ranking managers.

Military leaders and civilian policy-makers are committed to the maintenance of law and order so that nations remain free of internal strife. To do so necessitates strong military and police forces. If these units become debilitated by AIDS, if the internal peace-keeping forces of a nation are weakened, then the epidemic has struck at the very fabric of law and order.

What will happen when senior officers, highly trained pilots or police commanders become ill in large numbers and must leave the service? What will happen to the morale and discipline in the ranks, to the organisation and effectiveness of military units in keeping the peace?

Transmission in ranks

HIV poses a specific risk to soldiers because it is transmitted through blood and body fluids. By virtue of occupation, soldiers and sailors are at greater risk of injury during conflicts and training exercises. A prevalence of infection may compromise the safety of the blood supply in military hospitals. In countries with limited resources, contaminated equipment, including needles and syringes, may be a source of transmission.

Military leaders are also concerned about exposing their troops to HIV-infection from allies. A force with a low incidence of HIV may be reluctant to train and fight alongside a force with a high incidence of HIV, or rely on that force for medical support. This is a sensitive issue, and policies would need to encompass the concerns of both sides.

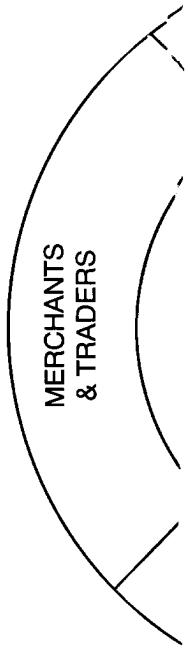
The fact that HIV/AIDS is a cross-border regional issue that forces neighbours to be concerned about infection levels in nearby countries makes the epidemic a potentially explosive issue. In complex ways, the epidemic will play a role in power struggles, in expansionistic thinking, in the calculations of special interest groups. Whether military units are able to carry out their missions and maintain national security will ultimately be determined by readiness in the ranks and stability of the leadership.

Prevention programmes

It is important that the armies of both Western and non-Western nations launch or expand AIDS prevention campaigns within their own military and police ranks. To addres seffectively some of the civil-military issues surrounding HIV transmission, they must reach out in co-operative ways to civilian groups.

It is possible to envision military personnel, perhaps those who have been recently demobilised, making contributions to AIDS awareness programmes as instructors and in some settings, as role-models. Civilian-military co-operative projects are possible; training missions between militaries can be jointly carried out in AIDS prevention. Military personnel can help national leaders reach the youth of their nations with important messages about AIDS prevention.

One of the greatest challenges facing military prevention programmes is to persuade troops to practise safe sex. Studies have shown that, during peacetime, STD infection rates among military populations are between two and five times the infection rates of the civil societies in which they reside. Indeed, evidence suggests that soldiers commonly consider the acquisition of an STD to be a peer symbol of sexual prowess and a proof of manhood. During wartime deployments, the military risk factor increases to as much as 100 times that for civilians at home.



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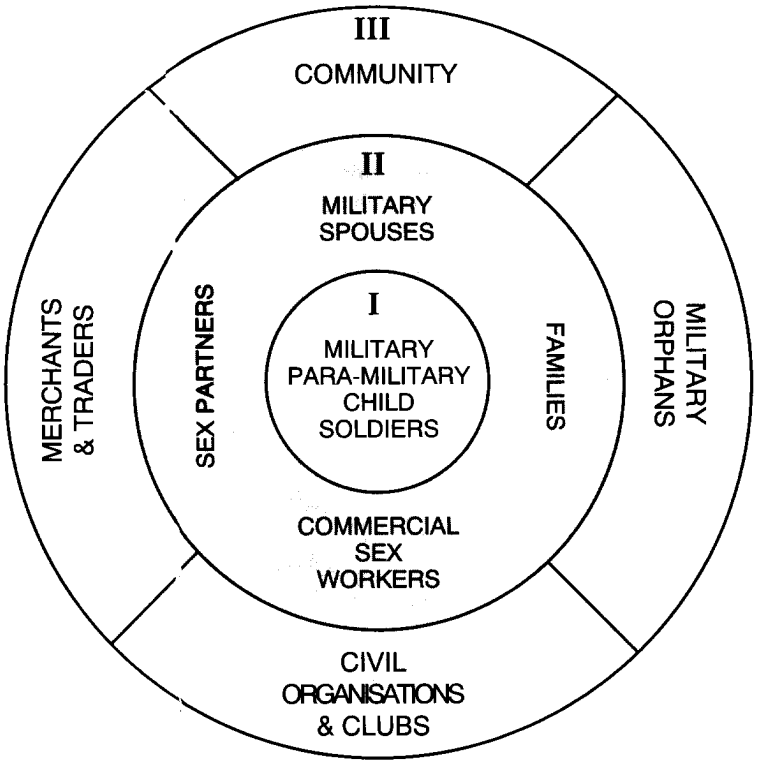

Effective military HIV/AIDS programmes have repercussions throughout the society.

Screening of recruits

One of the key issues facing military leaders trying to control the spread of HIV through their ranks is whether or not to screen new recruits for the virus. It is generally agreed that testing can serve several useful purposes, for example sentinel surveillance and improving blood safety. There are, on the other hand, important issues of privacy, confidentiality and human rights to consider. Crucial policy choices must also be made about the scope of testing and counselling, and about whether to maintain strict confidentiality of test results or to share them with the commanding officers and families of those tested.

The medical support required to care for individuals who are in the later stages of HIV infection is a problem. The military health care system may be compromised and unable to care for difficult long-term infections. This concern, combined with the fears of potential transmission, has resulted in policies in some nations to automatically exclude HIV-infected persons from the ranks.

Special military clinics

These concerns in turn lead to further questions. Should special AIDS clinics be established for soldiers and their families? At what point should HIV/AIDS patients be discharged and sent home. Should HIV-positive troops be deployed abroad? Should they be selected for advanced training courses and promotion in rank? Should the military pay for funeral expenses and medical costs of dependents? How much pension should be paid to families if the soldier dies at a young age?

On economic, security and human-rights grounds, the relationship between HIV testing and recruitment, training abroad, deployability and promotion must be carefully examined, evaluated and tested. Overseas training, in particular, represents a sizable investment in officer trainees and governments have a right to expect that such investment will be returned by service after training is complete.

Civil-military co-operation

This issue is made more complex by the high HIV-rates among senior officers in many developing country militaries, and raises the question — should officers be screened for HIV before they are promoted to senior ranks? At present, officers are very rarely subject to the same treatment as new recruits in this respect.

Though there are some very strong arguments for screening, it can have a negative social impact. Stigmatisation of those who may be rejected from the military because of their HIV-status may lead to much smaller numbers of candidates seeking military careers. If debilitating symptoms are slow to emerge in certain situations or can be delayed, there may be no good reason to deprive the HIV-positive of active service and of career-enhancing training, deployment experience and promotion in rank.

In this regard, STDs increase the risk of acquiring HIV, and HIV increases morbidity in STDs, STD control through education and counselling should therefore be viewed as a vital means of protecting against HIV, and close management of HIV patients should be enforced to delay the onset of AIDS. The highly regulated environment of a military setting is highly conducive to this kind of regime.

The consequences of failing to control the spread of HIV are ominous — social, economic and political destabilisation, permanent depletion of scarce financial resources from development budgets, civil-military strife, and the loss of domestic and international security. For these outcomes to be averted, prevention and care program
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rverted, prevention and care programmes must accomplish several purposes:

- greater training and co-operation and epidemiological data sharing must take place between the civil and military sectors;
- greater international co-operation in HIV-prevention must be encouraged through increased South-South, South-North and North-South information and resource sharing.
- the perception of HIV/AIDS as merely an immediate medical crisis and domestic political issue must be replaced by one that treats the disease as a serious but approachable long-term obstacle to national and international integration and peace.
- workable responses to HIV/AIDS can only emerge from intersectoral co-operation that moves beyond traditional ministerial distinctions in government, and also beyond time-honoured distinctions between the roles of military and civilian institutions in promoting common welfare.

Collaboration essential

Intersectoral and international collaboration are essential because HIV and AIDS recognise no boundaries and know no sovereignty. The epidemic violates borders as a part of the normal flow of trade and traffic.

It is part of the migratory patterns, refugee movements, military manoeuvres and peacekeeping missions. To stem the AIDS tide demands co-operation across borders and among neighbours, between civilian and military leaders and within military units. ■

Prof. Norman MIller is director of the Civil-Military Alliance to Combat HIV and AIDS. Prof. Rodger Yeager is Director of International Studies and Professor of Political Science at West Virginia University.

Secrecy within Indonesia's armed forces:

THE urgency behind the launch of Indonesia's national HIV/AIDS programme earlier this year does not yet seem to have been noticed by the armed forces. With active armed forces of 275,000 and reserves of 400,000 — the largest standing army in the south-east Asian region — their lack of support will be a significant gap in Indonesia's efforts to control the spread of the virus.

At a closed meeting with the WHO in September, military leaders gave a verbal commitment to launch a prevention and education programme for their troops, but would give no details about when the project would start or what it would involve. Even well-informed sources are not sure whether the vagueness was an attempt to keep the project secret, or the result of a lack of understanding about the epidemic.

Either way, the implications for the civilian AIDS programme cannot be good. The military's strong influence over the day-to-day running of government is well known in Indonesia. Its reluctance to initiate AIDS activities, or even openly discuss the need for them, begs the question — how effective can civil AIDS efforts be without military support?

The size of the reserve army illustrates the potential impact an effective military AIDS prevention programme could have. When they leave the army and join the civilian population, reserves could pass on prevention and education messages they learnt while in active services. But there have been neither national nor international efforts to exploit this opportunity.

So far, collaboration between HIV/AIDS specialists and the military is limited to scientific research, but even this is shrouded in secrecy.

The US army funds a research laboratory at the Indonesian National Institute of Health Research and Development in Jakarta. It analyses blood specimens with a view to tracking various strains of the HIV-virus — particularly strains C, D and E — in Indonesia and the surrounding region. Both the US and Indonesians are reluctant to discuss the project and will not reveal how or from whom the blood specimens are collected. But other sources suggest they come from conscripts and are collected through random testing.

One reason for the secrecy could be that the US does not want to advertise the fact that it is giving aid to a military condemned for its human rights abuse.

Thai army targets conscripts — to good effect

THE real evidence that HIV rates may be decreasing in Thailand was reported by the Royal Thai Army. ***Colonel Neal Boswell*** *looks at the role the Thai military has played in HIV/AIDS prevention and control, and how its efforts are helping the search for an HIV-vaccine.*

EVERY April, 21-year-old men in Thailand will engage in a nationwide lottery to determine who will be conscripted into the armed forces. Approximately 60,000 men are selected and enlisted either in May or November of the same year.

A lottery is used because it is seen as the fairest way to select conscripts. Its random nature ensures that soldiers come from a broad range of social, economic and educational backgrounds and are therefore an accurate representation of the wider population of that age. And, as they are also an easily accessible group, Thai conscripts are an excellent source of data for any sort of social or medical research.

For this reason, the Royal Thai Army (RTA) has carried out biomedical research and vaccine development for over 30 years. Many of these studies have been in collaboration with the US Army at AFRIMS (Armed Forces Research Institute of Medical Sciences), a jointly sponsored laboratory in Bangkok. Its HIV-data is perhaps the most representative of the general population as most other surveys are carried out among specific high-risk groups.

Limited data

Unfortunately, only limited demographic information has been gathered on the conscripts so far. But even the small amount of data available has had a major impact. RTA conscript studies were the first to identify the importance of other STDs and sex with female prostitutes as important risk factors for HIV infection among young men. Data from these studies was also used to develop a HIV/AIDS peer education intervention programme for young men on military bases. This was one of the earliest peer education programmes in the country.

Since November 1989, all conscripted men have been screened for HIV at the AFRIMS laboratory. But HIV+ soldiers are not disqualified from fighting. Professional, non-commissioned officers and officer corps are not tested.

In November 1991, a prospective study of the prevalence of HIV-1 seropositivity in RTA conscripts was begun using the scientific resources and infrastructure already present or developing at AFRIMS. Since 1991 smaller cohorts of these men have been followed for discrete periods of time to determine HIV-1 incidence data.

The first indication that the AIDS programme was working also came from the RTA. Studies from other agencies had shown that condom use among some men visiting CSW's had increased from 50% in 1989 to 90% by 1992. But a true decrease in HIV-incidence was not reported until Thai military and US military investigators (in collaboration with the

political factors at work?

by Linda-Jane Buckle

The laboratory is also capable of DNA sequencing and its research has helped track the movement of the HIV virus through the region. Staff believe they can trace the introduction of the HIV virus into south-east Asia down to a single traveller from equatorial Africa.

Indonesia has been slower than other countries in the region in acknowledging the potential impact of HIV/AIDS, but it now has a substantially funded, multi-sectoral programme in place (*AIDS Analysis Asia*, Vol. 1 [4]).

Recent figures confirm that the programme is badly needed. The number of people testing HIV-positive has doubled in nine months. In mid-1994, USAID estimated that 45,000 people out of a population of 180m were HIV-positive; by spring 1995 the estimate had risen to 90,000. These figures suggest that infection rates in military ranks are already high. If the armed forces is to prevent further spread, it must act fast to implement a comprehensive programme and begin forging links with civilian AIDS efforts.

In countries such as Thailand extensive co-operation between government ministries and the military have aided effective implementation of the country's AIDS programme. But in Indonesia such collaboration is still a long way off.

The first step will be to resolve many basic policy questions, such as whether new recruits should be tested for HIV. Screening seems to be ruled out, for now, but only because no funds are available to implement such a programme. The question of what the navy should do about the brothels it operates in downtown Jakarta also needs to be answered urgently.

Indonesia's renowned sensitivity about its military, and its poor international reputation, is bound to make the process of implementing an effective programme a painful one. For example, USAID — among other NGOS — has already said that it could not work with the military because of its human rights record.

In the meantime, the Indonesian military, like many other militaries will need to rely on the impact of civil HIV/AIDS prevention programmes to protect its troops.

There are many such projects, but alone they will not be enough to prevent the rapid spread of HIV/AIDS in the military. If the country's military leaders do not address the problem of HIV/AIDS now, they will be forced to do so later. ■

Henry Jackson Foundation and Johns Hopkins University scientists) reported this year that overall prevalence among RTA conscripts dropped from 3.7% in 1993 to 3.0% in 1994. The decrease was observed among men from all regions of the country, from both rural and urban areas, and at all educational levels. The research is further substantiated by the falling STD rates reported at public clinics.

Vaccine development

The collaboration between the RTA and the US Army has another, very significant, dimension. AFRIMS is an extension of the Walter Reed Army Institute of Research (WRAIR) long recognized as one of the world's premier vaccine development and testing centres.

According to Lieutenant-Colonel John McNeil, Clinical Head of the HIV Vaccine Development Group at the WRAIR, Thailand is particularly well suited to play a pivotal role in the global search for an HIV vaccine. A key reason for this is the Royal Thai Army's commitment to helping trial prospective vaccines. Other important factors which make Thailand a suitable test site include: a high HIV-infection rate in the general population; a well-developed research infrastructure, as evidenced by recent successful trials for Japanese B encephalitis vaccine and hepatitis A vaccine; and the commitment of the government to the development of an HIV-vaccine.

This commitment was advanced significantly in August 1995 when RTA, US Army, and Henry Jackson Foundation scientists began a Phase 1 HIV vaccine trial in Bangkok and Chiang Mai. There are also plans to trial a vaccine designed to protect against the strains of HIV most common in Thailand - HIV-1 E genotype - within the next 1-2 years. This will be the first such vaccine either manufactured or tested. Until now, most candidate vaccines have been based on strains of HIV common in Europe and the US.

Vaccine trials

Since the National Institute of Health abandoned vaccine trials in the United States in 1994, Thailand has become the 'hotbed' of HIV vaccine trials and research. The potential for evaluating the efficacy of vaccines there can not be duplicated anywhere else in the world. The high level of HIV in the general population means that smaller trial sample sizes can be used with shorter follow-up times. Thailand's highly developed health and research infrastructure means there is potential to 'multi-arm' trials — comparative trials involving many different candidate vaccines. In addition, the involvement of broad-based population groups in Thailand's national response to AIDS means that scientists do not need to focus on behaviourally defined — and often socially marginalised — populations.

The Thai Ministry of Defense has developed its HIV/AIDS prevention and control programme in tandem with the MOPH and other governmental and non-governmental agencies and has already made significant contributions to the national programme. The HIV vaccine development programme, ensures that the Thai military will continue to play an important and influential role in both the prevention and control of AIDS in Thailand. ■

Colonel Boswell is Director of Laboratory Services, Retrovirology Division at the Walter Reed Army Institute in Rockville, USA.

Running towards an Indian 'sexual revolution'

IN July, India was rocked by an advertisement for running-shoes. Posters appeared showing two well-known models — one male and one female — wearing nothing but trainers. It was the first time the advertising industry had displayed nudity, and its daring was hailed as evidence of a 'sexual revolution' in the country. But the storm of protest the advert raised shows that if attitudes towards sex and sexuality are changing, the process is a painful one. ***Veena Lakhumalani*** *gives her view on India's transition.*

OVER recent years, India has seen a marked increase in articles, discussions and debates in the media on issues related to sex and sexuality. Both print and electronic media are becoming more and more open. In addition, there has been a phenomenal expansion of TV channels and networks which expose people to round-the-clock suggestive, often vulgar, song-and-dance routines from India's so-called 'Bollywood'.

Sex on the silver screen

Indeed, the Indian film industry has undergone a drastic transformation. Its sound-tracks, dance routines and costumes are often provocative and the sexual undertones nauseating — heroes and heroines jerk and gyrate their pelvises with unbelievable monotony. Strangely enough, these films seem to appeal to both young and old, men and women, girls and boys. In contrast, the older generation frowns upon 'bedroom' and 'kissing' scenes in imported soap operas such as the 'Bold and Beautiful' and 'Santa Barbara' which are popular with young people. Such behaviour is considered 'Western'.

Three decades ago, the Indian public had little choice when it came to buying magazines. Today, the choice is vast. Soft-core pornographic journals, gay journals, large numbers of ciné publications are all available, though the authorities are uncomfortable about their existence. Recently, publication of *Debonair*, India's answer to *Playboy*, was forcibly discontinued by the police in Bombay. Other journals fear the same treatment. But such attempts at censorship are unlikely to check the increasing frankness with which almost all leading newspapers and magazines are now discussing sex and sexuality.

Even the electronic media, both state-owned and private, have an open mind in this regard. Films such as the 'Valley of the Dolls', advertisements for condoms and sanitary napkins and discussions with representatives of the gay community are no longer unusual viewing. Another example of society's changing attitudes is the first-ever Indian film — currently being made — about homosexuality. While 'Adhura' is unlikely to be a box-office hit, it will certainly provide plenty of food for thought and public debate.

Sexual revolution?

Does this new explicitness in the media represent a 'sexual revolution'? Have cultural and moral values undergone a radical change to suit today's world? If they have, the transition can in part be attributed to the emergence of HIV/AIDS as a major threat, socially, physically and economically, and the frank discussions it necessitates.

Certainly, there is a great divide between the attitudes of the older and younger generations on any aspect of sex. A glance at the daily newspapers makes this clear. Just one example is the controversy sparked by the Bombay Municipal Corporation's recent decision to introduce sex education for 14-17-year-olds.

Several educationists and parents made strong public statements to the effect that if students are provided with information about sex and sexuality, safer sexual practises, homosexuality, HIV/AIDS and STDs, the result would be an increase in sexual activity, unwanted pregnancies and HIV-infection. The authorities responded that education is the only way to protect youngsters from such risks.

A similar controversy was caused when a leading English-language newspaper in Calcutta introduced a half-page column entitled ASK (AIDS, Sex and Knowledge) in a weekly supplement for its young readers.

Letters poured in from young people expressing gratitude to the agency for running the column and scores of enquiries on sexual behaviour and AIDS were received.

However, letters from parents and adults also poured in, many expressing strong disapproval that such explicit information was being passed on to youngsters. Their concern is an indication of how out-of-touch the older generation are with their children: surveys of red-light areas in Calcutta, Bombay, Pune and other cities reveal that between 8% and 30% of the clients of sex-workers are students.

The *Kama Sutra*

This conservatism has no links with ancient Indian culture. Centuries ago, the *Kama Sutra* gave undiluted and unrestrained information on sexuality. Ancient Indian art and architecture was equally uncensored. Konarak and Khajuraho temples both house beautifully carved sculptures depicting heterosexual, homosexual and group sex, a recognition that sexual activity is a natural part of human behaviour. Certainly, if sculptures and paintings are a measure, then Indian women in ancient times wore clothes that revealed more than they concealed, and they appear not to have been ashamed of their sexuality.

Why, then, did attitudes change? Konarak, Khajuraho and other such temples were built between the 11th and 13th centuries. Soon after, Muslim invaders arrived in India. Perhaps they brought orthodoxy and conservatism with them along with purdah and the veil? A few centuries later, the British came with their Victorian values. These historical changes no doubt changed social norms, and resulted in new attitudes towards sex.

STD-control is no 'magic bullet' says the WHO

THE WHO and some scientists have reacted with caution to research from Africa which shows that HIV transmission could be almost halved if other sexually transmitted diseases are treated effectively (*AIDS Analysis Africa*, Vol. 5 [6]).

In a letter sent to *The Lancet*, the World Health Organisation points to some problems in the study and argues that an over-reliance on STD programmes would be a mistake. 'It is important that comprehensive STD management be implemented in combination with interventions to change sexual behaviour,' says the letter.

'While not wanting to diminish the results, we are concerned that STD treatment alone may be viewed as the 'magic bullet' of AIDS prevention', the letter emphasises.

'This is a valid and very useful study', says Dr Chandra Mouli of the World Health Organisation's Global Programme on AIDS, 'but it is important to remember that even if all other STDs were wiped from the face of the earth, HIV would continue to spread, albeit at a reduced rate.'

There are wider concerns in putting too much faith in control of STDs. 'The patterns of STDs are very different in different parts of the world', says Dr Mouli, 'and individual STDs vary in the efficiency with which they facilitate transmission of HIV. There are also financial and logistical reasons why such interventions will not always work.'

Mouli's comments are echoed by Dr Tony Klouda of the International Planned Parenthood Federation. 'This is an important, well done and honest study, but my gut reaction is that it won't make a significant difference in terms of HIV reduction,' argues Klouda.

'AIDS is a symptom of underdevelopment. It shows up where health services are weak, where women's position is weak, where employment opportunities are limited. Unless you deal with those conditions, you won't make a substantial difference in terms of HIV reduction', argues Klouda.

But according to Heiner Grosskurth, principal researcher on the study, the criticism 'misses the point'. 'The study had only one parameter — does STD-control affect the spread of HIV, yes or no. We did not looking at how the change sexual behaviour, and we are not suggesting that STD-control can replace IEC campaigns. I am worried that people will jump to the wrong conclusion, and say that because the behaviour of the study group did not change, IEC campaigns do not work.' he said.

The Mwanza project demonstrated that improved STD treatment leads to a significant reduction in the incidence of HIV. In the groups receiving treatment, 1.2% of patients had become infected with HIV over the period of the trial. In the control group not receiving treatment, the figure was 1.9%.

Key to the project's success was the low cost of treatment. Rather than use the most powerful treatments, which cost $10 a dose, the team used high dosages of much cheaper drugs, such as Septrin, a two-day course of which costs about 70 cents.

The most difficult problem for the widespread implementation of STD programmes is that up to 90% of STDs do not cause symptoms, and sufferers therefore do not seek treatment. And, according to Klouda, although the Tanzania study claims to have been implemented at low cost, this does not address the more complex question of how to deliver treatments effectively.

'A measles vaccine costs a couple of cents but millions still die from the disease', he points out. 'The problem is not just that of treatment, but also of establishing the infrastructures that can get health services to those who need them.

'While medical technologies such as condoms and STD treatment are extremely important and must be developed,' argues Mouli, 'it is essential that approaches such as this do not sideline the other two pillars of AIDS prevention — education and motivation of people on the one hand, and the empowerment of vulnerable groups, such as women, on the other to protect themselves from HIV.'

No one, however, is doubting the importance of this study in providing firm evidence of why HIV has spread so fast in many developing countries, particularly those with the poorest access to health services. ■

INDIA (cont): women governed by male dictates

While explicit behaviour may now be tolerated on the screen, it is not clear whether people are transferring these values to their everyday lives. Most women in India remain governed by social norms that are dictated by men.

But things are changing. In urban areas, many young women have made rapid strides socially, economically and politically. The younger generation as a whole is breaking away from tradition, as their writings, films, discussions and attitudes all show.

Modern society

A key change has been the increasing acknowledgement and acceptance of pre-marital sex, extra-marital sex, alternative sexuality, and child sex abuse. Traditionalists prefer to consider such issues as 'Western'. But privately, most elderly people admit that sexual behaviour is not very different today from what it was one or two generations ago.

India is a society in transition, a country where contradictory social values can co-exist. A large number of women may have gained economic and social liberation, but many others continue to suffer from dowry-related physical abuse and even death. It will be years before women in urban and rural India achieve sexual liberation. But perhaps a celluloid liberation is the first step. ■

Veena Lakhumalani is Senior Projects Officer at the British Council in Calcutta.

Predicting the economic impact of AIDS in Thailand: a difficult sum to calculate

By the year 2000, Thailand will be caring for 300,000 people with AIDS. In that year alone, 180,000 people with the disease are expected to die, accounting for a third of all deaths. It is now clear that the strain of the disease will affect not just families, communities and health workers, but national development itself. The question is, how? ***Manisri Putularb*** *and* ***Shakti R. Paul*** *look at the economic dimensions of the AIDS epidemic in Thailand.*

BEFORE any predictions of the possible economic impact of AIDS can be made, it is first necessary to chart the history of the epidemic and try to estimate its future course, including the number of people who will be infected, over the next few years.

In Thailand, the AIDS epidemic has occurred in several, overlapping phases. The first phase was among homosexuals, most of whom had returned from abroad or had some contact with foreigners.

In the second phase, large numbers of Injecting Drug-Users (IDUs), who lived mainly in clusters such as prisons and urban slums, were infected. In the third phase, female prostitutes contracted the disease from the infected IDUs and homosexuals. Many male clients of the prostitutes then contracted the virus in the fourth phase. In the fifth phase, these infected men passed the virus on to their wives, girlfriends or other sexual partners. By the sixth and final phase, the children of infected mothers became infected.

The epidemic has been geographically concentrated in the northern region and in Bangkok and its surrounding areas. Later, HIV and AIDS began to emerge in the previously 'low infection areas' of the north-east and south.

In 1991, the Thai government Working Group on HIV/AIDS made projections on the growth of HIV-infection in Thailand to the year 2000. It used the 'iwg' AIDS model, a behaviour-based method which requires data on demography, sexual and drug injecting behaviour, epidemiology and blood banking. The study produced both a 'high' scenario and a 'low' scenario, and estimated that:

- from 1991 the number of people infected with HIV would grow from 160,000 to between 3.4m and 4.3m by 2000;
- while more men were infected in 1991, more women would carry the virus by the year 2000;
- people aged 15-44 years would be worst affected;
- between 1991 and 2000, prevalence rates among the urban population will increase from 0.9% to 11.2%, while rural prevalence will increase from 0.12% to 2.50%.

In 1993, Tim Brown and Werasit Sittirai used a different method and came up with a higher projection. The following year, a NESDB (National Economic and Social Development Board) Working Group study produced a much lower estimate. It projected 1.5m HIV-infections by the year 2000 with a 'baseline' intervention programme, 1.3m with medium intervention and 1.2m with high intervention programme.

Direct Costs

The first comprehensive analysis on the economic impact and cost of the epidemic was attempted by M. Viravaidya, S. Obremskey and C. Myers in 1991, based on figures from the Thai Working Group. Using the low and high scenario projections (*see Figure 1*) they calculated the direct and indirect costs of the epidemic, using high and low cost estimates for each category.

Included in the 'direct costs' were in-patient and out-patient care, which together amounted to $658-$1,016 per person per year. At the time, the amount was equivalent to between 30% and 50% of average household income.

The research also estimated that, on average, patients live for one-and-a-half years after the onset of full-blown AIDS. Treatment for illness of this length would cost between $987 and $1,016.

The number of additional hospital beds that would be needed to care for the increased number of AIDS patients, at a rate of $16,000 per bed, was also calculated. Adding together the cost of treatment and extra beds, the total direct cost of AIDS was $909m using the high scenario and $751 using the low scenario.

Indirect Costs

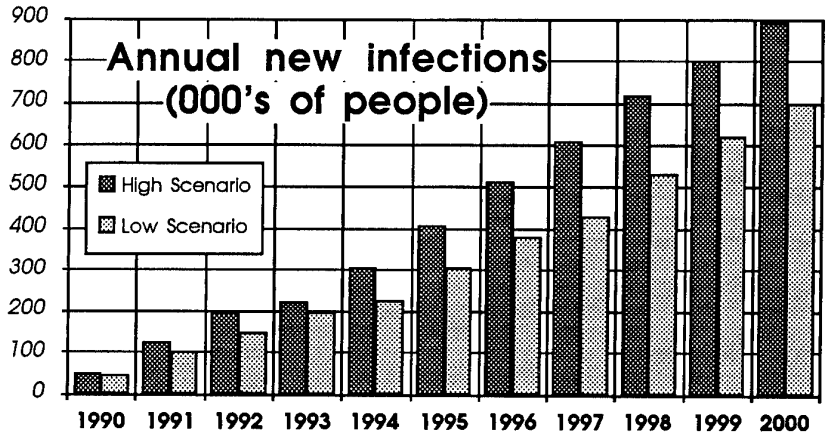
The study also attempted to estimate the possible 'indirect' costs of the disease. Most of the men infected with HIV in Thailand are in their thirties, while women tend to be in their twenties and thirties. This suggests that each AIDS patient will lose 25 years of 'productive' life. If each of those years is worth $1,500 (national gdp *per capita* is $1,250), the total indirect cost of AIDS by the year 2000 would be $7.3bn using low scenario and $8.5bn using high scenario. For every affected family, this is equivalent to a 'loss per death' of $22,000.

In 1991-92, $100m was spent on HIV/AIDS prevention and control. If those activities are effective in changing people's behaviour, some 3.5m infections could be avoided, saving not only lives but $5.1bn by the year 2000.

In 1992, another study calculated the cost of caring for patients with AIDS and AIDS-Related Complex (ARC) in 26 provincial (public) hospitals. Routine care, medical care (including laboratory tests and drugs) and external costs (all other expenses of the family to support the admission) amounted to $13.65, $169.46 and $46.16 respectively. Based on an average 12 days' admission, the total cost per admission was $229. Combined with reliable epidemiological data this cost estimate could be used to predict the cost to health services of caring for AIDS patients.

In 1994, a study team from

Figure 1: Two forecasts of Thai HIV rates



Chulalongkorn University looked at the impact of AIDS on rural households in northern Thailand (*AIDS Analysis Asia*, Vol. 1 [1]). It found that the lowest income group in the village was worst affected by the disease. The burden placed on these households by the high cost of medical care is severe, averaging $1,000 from the beginning of illness until death. This is equal to six months' average household income.

The income lost when an AIDS patient stops working also represents a substantial loss for the family — on average $155 per month or $1,860 per year. In total, the cost of medical care and lost earnings of a 'regular income' person was calculated as $31,268. If supplementary income was included, the amount lost would increase to $242 per month, $2,904 a year or $50,226 per death.

It was also found that government-supported free medical programmes or voluntary nsurance schemes did not help the lowest-income groups in rural communities. Families were meeting the costs of AIDS by reducing their consumption, dipping into savings, selling assets like land, jewellery and livestock, borrowing money and withdrawing children from school.

Health Economics of AIDS

The limited number of studies reviewed here show the difficulties that are involved in calculating the economic impact of AIDS. Traditionally, economists estimate the financial burden of a disease by considering direct, indirect and other intangible costs borne by the person, family and society.

Direct costs include the treatment provided by health centres and hospitals; additional hospital beds and equipment such as gloves and disposable syringes that may be needed; the need to re-train staff in AIDS care and prevention; the cost of treating increasing numbers of TB patients; blood screening; and prevention and education campaigns.

Discrimination

Indirect costs include the lost earnings of the patient; the cost to relatives of hospital care; reduced savings for investment; fewer assets as jewellery, livestock, etc, are sold off; and indebtedness. In addition, relatives may have difficulty finding work because of discrimination, and poverty may force families to withdraw children from school. The reduced national labour force and possible reduction in tourism and investment are also considered.

Intangible costs are difficult to calculate. They include the social discrimination, and the impact of the breakdown of the traditional family structure.

One of the main problems in trying to assess the economic costs of AIDS is that different authors use different combinations of indicators. In addition, estimates of the same indicators can vary. If such calculations are to be of use, it is imperative to standardise them.

These problems are particularly apparent in the calculation of indirect costs. In 1993, M. Viravaidya *et al* estimated indirect costs per death at $22,000, while in 1994 S. Pitayanon *et al* calculated it at $31,268 for a regular-income person.

If the later estimates were used for the national calculation, then the indirect cost of AIDS in Thailand would be about $15bn-$20bn for the period 1991-2000.

As they stand, current cost analyses do not take three important issues into consideration. First, the distribution of the impact — of concern in all countries affected by AIDS. High-risk groups, such as prostitutes, migrant labourers and truck drivers, come from the poorest sectors of society. Many may not have access to information or education about AIDS and its impact.

Second, the position of ethnic minorities. In northern Thailand, intravenous drug-use and prostitution are common problems among minority groups. These groups are often poorly educated and have little access to information.

Third, migrants — both legal and illegal — are especially vulnerable. There are foreign prostitutes in Thailand who for legal and financial reasons do not seek health care. Because they speak a different language, they receive little information about AIDS and its prevention. Labourers, truck drivers and fishermen are in a similar situation. There is also a risk that, because they are a highly-mobile population, this latter group will transmit the virus to others.

Final words

AIDS remains a serious challenge to Thailand and the rest of the world. The direct cost of the disease imposes constraints on scarce resources, but the largely unappreciated indirect cost — 15 to 20 times more — could be catastrophic. Individual households, society and the nation as a whole will suffer. ■

❑ Meechai Viravaidhya, former head of Thailand's National AIDS Committee, told the recent conference on AIDS in Chaing Mai that the epidemic would cost his country's economy 155bn Baht ($6.2bn). Already, Thai workers identified as HIV-positive have been refused permission to land at Indonesian ports.

Manisri Putularb works at the Centre of Health Economics, and Shakti R. Paul at the Asian Research Centre for Migration, Chulalongkorn University, Bangkok.

Alarm bells ring in impoverished Bangladesh

THE plane is tiny so it takes people some time to stuff their bulky, heavy luggage into the overhead lockers. Once everything is stowed the flight from Calcutta to Dhaka takes no time at all. On landing, the passengers — mostly men — get up quickly and hurry off. There is nothing unusual or untoward about the scene. Indeed, there are thousands of flights between Bangladesh and India every year. That is the problem.

Bangladesh exports textiles, ready-made clothing, jute and fish products. It also exports its people, usually married men looking to improve family income. Apart from India, Bangladeshi men travel to the Middle East and to Thailand for work.Bangladesh is also a very poor country. There is one doctor for every 7,000 people and the adult literacy rate is 47% for men and 22% for women. Some 84% of the population — 100m people — live below the poverty line.

Statistics like these ring alarm bells for anyone who links poverty and illiteracy to increased risk of HIV infection. In the Bangladeshi cultural context, in particular, the lack of openness about sex, increases this alarm to near panic.

One group of village women told me a story about a woman who had an affair. When the woman tried to end it, her lover burned her with acid. The police refused to investigate the incident until women took to the streets in protest demanding justice. But they stressed that they had only taken the action because of the horrific injuries the woman had suffered. Although they felt that justice had been done, they roundly condemned the woman for her involvement with the man.

I asked the group if women were expected to be virgins when

by Mary Conill of Christian Aid

they married. The said the answer was obviously 'yes'. When I asked whether the same was expected of men they said yes, but that virginity could not be forced or guaranteed among men. I took this to be a cautious answer and tried to probe a bit further but it seemed that they did not want to think further about it. They said simply that men have all the freedom.

Access to education, work, even the right to come and go without fear of censure or harassment, are denied to most Bangladeshi women. Though it is not a fundamentally Muslim society, the few freedoms women have are being threatened by the increasing control of the mullahs.

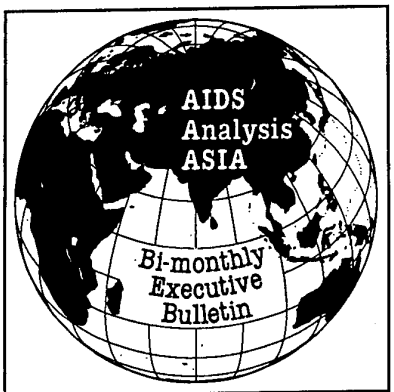
By March 1995, 39 people in Bangladesh had tested HIV-positive. However, the WHO estimates that there could already be 20,000 people with the virus. Dr Nasir Uddin of Voluntary Health Services Society (VHSS) says the government has adopted an ambiguous response to the possibility of an epidemic.

There is a National AIDS Committee but it has been slow in forming an Information, Education, Communication Plan to raise awareness. It also refuses to disclose any information on the seriousness of the situation.

In the absence of a government service, non-governmental organisations are being encouraged to fill the vacuum. At present, there are only six official HIV-testing centres. People cannot get access to these places on their own, but must be referred by doctors. Unfortunately, few doctors are able to recognise the symptoms of AIDS as there has been no specific training programme to assist them.

On the positive side, official bodies have begun to display a sense of urgency about AIDS over the last three years. The change has come about with the emergence of data on the high incidence of STDs among commercial sex-workers, long-distance truck drivers and professional blood donors.

Dr Uddin takes heart from the fact that the chairman of the National AIDS Committee is also the deputy leader of the parliament and is therefore a senior politician. This seems to indicate that the government is at least worried about the epidemic, and realises that it simply has not the resources to deal with large numbers of people with AIDS. The problem is, it does not seem to know how to respond. ■



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Deputy Editor: Rebecca Dodd BA
Consultants: Professor Alan Whiteside, Norman Miller
Subscriptions: Katrina Good
Marketing: John Swainston
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Editorial & Administration office:
Suite 71, Ludgate House, 107-111 Fleet Street, London EC4A 2AB, England
Tel: 0171 353 1117, Fax: 0171 353 1516
E-Mail: africa analysis@mcr1.poptel.org.uk

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Civil-Military Alliance: Defining the Territory

Who are the individuals and the organizations of special concern to the Alliance? In Figure 1, at right, these are seen at three levels.

I. The central focus is military, paramilitary and child soldiers. The central concern is changing their behaviors in terms of risk of HIV and AIDS. Women in militaries around the world are a special concern.

II. Military spouses, children and extended families who often live with or near a member of the military, are an important concern as are other sex partners and commercial sex workers.

III. Surrounding military personnel and their families is a broader sector that includes individuals such as military orphans and child merchants and traders, as well as the communities near military facilities, local and national government offices, and civilian organizations such as churches and other non-governmental organizations.

Figure 1

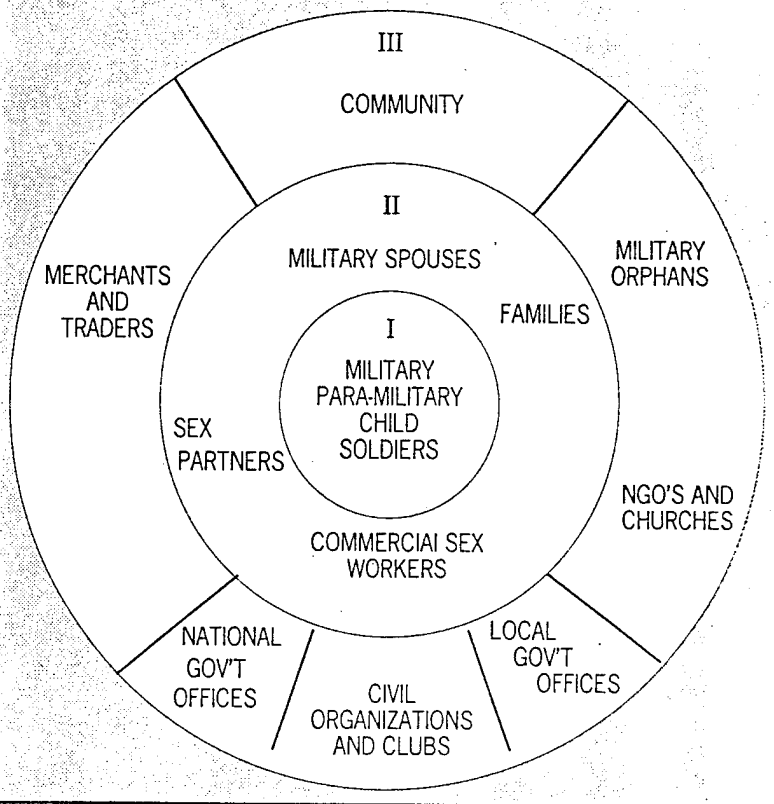


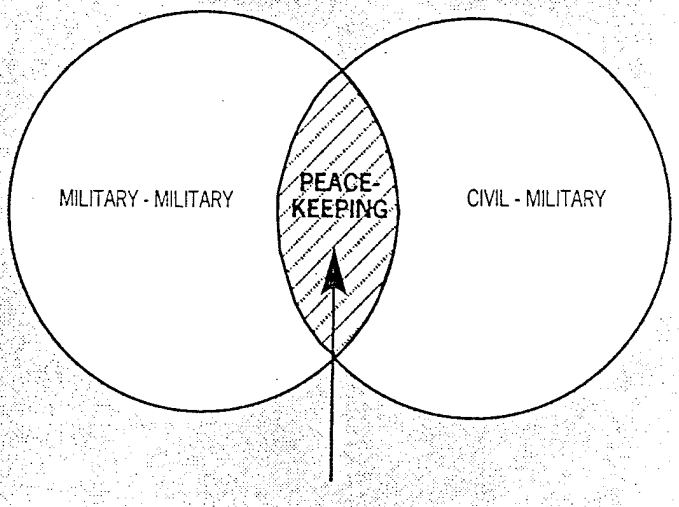
Figure 2

INSTITUTIONAL RELATIONSHIPS

MILITARY - MILITARY

ISSUES

Prevention and Care
Clinical Treatment
Joint Training
Behavioral Change
Policy Issues Concerning
Soldiers With HIV/AIDS



CIVIL - MILITARY

ISSUES

Demobilization
Soldiers as Educators
Military Wives and
Families
Civil-Military Communities
Prostitution
Development

PEACE-KEEPING

ISSUES

Testing, Troop Briefings and Education, HIV Transmission in Blue Helmet Missions,
HIV Transmissions Following Blue Helmet Missions, Diplomatic Issues

CONSENSUS STATEMENT

MILITARY AND CIVILIAN COOPERATION IN RESPONSE TO THE HIV AND AIDS EPIDEMIC

WHEREAS the world now faces a disastrous global epidemic of HIV and AIDS;

Whereas HIV recognizes no boundaries and knows no sovereignty;

Whereas military communities are at risk of HIV and AIDS;

Whereas the HIV and AIDS epidemic is both a serious public health problem and a threat to social and economic development;

Whereas the HIV and AIDS epidemic in many parts of the world poses a potential threat to political stability and national security, and is a potential hindrance to peace;

RECOGNIZING the critical role of a unified, effective, and sustainable national response to the epidemic;

Recognizing further that effective and sustainable HIV and AIDS prevention and care policies and programs demand close cooperation between military organizations and local, national, and international civilian organizations;

WE HEREBY URGE that military organizations around the world:

Immediately cooperate to combat HIV and AIDS as a common threat;

Share lessons learned in the effort to develop effective sustainable prevention and care policies and programs;

Ensure that persons with HIV and AIDS are always treated with dignity;

Provide compassionate health care and social support for persons with HIV and AIDS;

Strive to dispel irrational fears about HIV and AIDS in the military environment;

Recognize their capacity for care and prevention in both military and civilian communities; and

Participate in global HIV and AIDS research; and

WE COMMIT ourselves to the fostering of a spirit of cooperation and the sharing of experiences between military organizations and the communities in which they live and work in our common struggle against the HIV epidemic.

This statement was adopted by participants who organized the Civil-Military Alliance to Combat HIV and AIDS at a conference in Rockville, Maryland, USA, Nov. 20-22, 1994. The Consensus Statement originated at the Seminar on HIV/AIDS in Military Populations Around the Globe, Berlin Germany, 6 June 1993. Individuals came from the United Nations (UNDP, WHO) ministries of defense, military health organizations, national HIV and AIDS programs, bilateral donor organizations and others. Countries represented at the two meetings included:

Australia
Belgium
Brazil
Canada
Congo
France
Germany
Greece
Honduras
Indonesia
Italy
Kenya
Korea
Mexico
Morocco
Netherlands
Norway
Peru
Philippines
Portugal
Russia
Rwanda
Senegal
Switzerland
Thailand
Turkey
Uganda
United Kingdom
United States
Zimbabwe

The Newsletter of the World Health Organization Global Programme on AIDS

GLOBAL AIDS NEWS

New alliance focuses on civil-military issues

Representatives of Defence Ministries, military medical services, national AIDS programmes, UNDP and WHO have set up a *Civil-Military Alliance to Combat HIV and AIDS.*

Established in November 1994 at a three-day conference in Rockville, Maryland, USA, the Alliance will address the prevention of HIV infections among military personnel, their families and the communities with which they mix. It already has members from more than 40 countries.

HIV prevalence is usually higher among military personnel than in the general population (Photo: WHO/G. Diez)

"The overall mission of the organization is to focus on issues of prevention, education, policy and care in civil-military settings," director Norman Miller writes in an inaugural newsletter called *Alliance*. Miller is a Professor at Dartmouth Medical School and also editor-in-chief of *AIDS and Society*.

Since 1986, more than 7000 men and women on active duty in the US armed forces have been found to be infected with HIV. Four thousand more have been denied entry to active duty. The total cost of the epidemic for the US military has been projected at between 1 and 2 billion dollars.

Colonel Donald Burke, Director of the Retrovirology Division in the Walter Reed Army Institute of Research at Rockville, USA, sees several reasons why HIV/AIDS has a military importance:

- It may compromise combat readiness in places where many highly-trained officers and

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African armed forces and police discuss AIDS/STDs

About 500 delegates from 12 African and four non-African countries gathered in Yaoundé, Cameroon on 23-24 February 1995 for the First (African) International Medical Conference of the Armed Forces and Police. Sponsored by Cameroon's Ministries of Defence and Public Health, the conference focused on STDs and AIDS. STD rates are often at least twice as high among military personnel as among civilians, and both STDs and HIV/AIDS are major health problems among the police and military populations throughout the African region. The representatives of several countries acknowledged that AIDS had become the leading cause of death among serving military personnel.

The African countries represented were: Benin, Cameroon, Central African Republic, Congo, Côte d'Ivoire, Gabon, Guinea, Nigeria, Rwanda, Senegal, Togo and Tunisia. Representatives of Belgium, France, Germany and Switzerland also took part, as did AIDSCAP, the Pasteur Institute and WHO.

Reprint

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noncommissioned officers are infected;

- High prevalence in both civil and military populations, such as in Rwanda, may be a cause of political instability;
- Troops deployed to high-prevalence areas may be so worried about getting infected that they will avoid all contact with blood or refuse blood transfusions.

The Alliance identifies three broad areas in which it wishes to be active:

Military-to-military. Collaboration on HIV prevention and care between the armed forces of different countries. This might include joint training seminars on clinical treatment and ways to encourage behaviour change in specific settings.

Civil-military. Prostitution around military bases is of growing concern, since the risk of HIV transmission has been added to the risk of getting some other sexually transmitted disease. Large-scale demobilization, especially where HIV/AIDS is already present among the troops, is another issue affecting both military and civilian populations. The Alliance also hopes to draw attention to the need for military wives and families to be educated about HIV/AIDS and have access to condoms.

Peacekeeping. Over the last 15 years, more than 600,000 blue-helmeted United Nations peacekeepers have been deployed on 17 missions. The Alliance believes that more peacekeepers have died of AIDS – or will die because they have been infected with HIV — than have lost their lives in the line of duty. It hopes to provide or facilitate briefings for UN soldiers, and to explore such issues as pre-deployment testing and risk reduction both before and after deployment.

A first financial grant for the work of the Alliance, which will initially be based in Washington DC, has been provided by the US Agency for International Development. Eventually, it is expected that the secretariat will move to Europe. ◘

Harare meeting examines AIDS prevention in military

Delegations from Botswana, Kenya, Malawi, Tanzania, Uganda, Zambia and Zimbabwe met in Harare, Zimbabwe in May to examine policy issues and technical aspects of AIDS prevention in the armed forces. Designed as both a policy consultation and training seminar, the meeting was co-organized by GPA, the World Bank Economic Development Institute and the Civil-Military Alliance to Combat HIV and AIDS, in consultation with the United Nations Department of Peace-Keeping Operations. The high-level seven-person delegations included officials from the Ministries of Defence, the military medical and nursing services, and national AIDS programmes.

Subjects of long discussion included: the increased risks of infection with HIV and other STDs faced by military personnel posted for long periods away from home; the special vulnerability of women and youth; and the particular circumstances of troops deployed on peacekeeping missions. Delegates recognized that countries in Eastern and Southern Africa required a more effective working relationship between their civil and the military AIDS programmes.

In addition to planning further initiatives together, the seven countries decided to convene a workshop on policy reform in Malawi this October. The World Bank, GPA and the Civil Military Alliance agreed to support the meeting, which is aimed at top decision-makers in defence and health ministries.